Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

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Obiter Dicta

The C.H.C. Meeting in Quebec

THE biennial meeting of the Canadian Hospital Council in Quebec City, May 26-28, will again enable hospital workers from coast to coast to discuss many of the present situations which are of vital interest and concern to hospitals. Advance information would indicate a full attendance of delegates from the various hospital associations and conferences, as well as from the federal and provincial governments. As in past years the meeting will be essentially that of a council, not an association convention; formal addresses will be subordinated to a general discussion of selected topics and all delegates will be expected to contribute to the discussions.

Among the topics to be considered will be the present national health program and its implementation in the provinces; the scope of provincial surveys; construction grants; personnel training and education. The present nursing outlook, and the steps being taken (or not being taken) to correct the situation will be discussed. Blue Cross and compulsory hospital insurance will be gone into, as will also such topics as hospital accounting, transfusion services, the development of standards, educational programs for administrators, and hospital financing. The place of the hospital and its medical, nursing, and technical staffs in the program of national defence, will be reviewed. The role of the national and provincial hospital organizations in a program of public relations will be considered. The executive committee will meet all day on the Wednesday preceding the Council meeting.

Of particular importance will be the discussion on the work of the Council, the degree to which it should expand its activities to meet the needs of the hospital field, and how these undertakings could be financed. The Canadian Hospital Council has been of tremendous service to the hospital field and is constantly giving evidence of the necessity for such an organization. But it could be of much greater service if it could only have the staff and the funds to undertake some of the many tasks which need attention. Every month many requests come in for information or help which cannot be furnished because the Council has not yet been able to study that particular situation or detail. These are momentous days in the health field, for the national health program has stimulated greater developments than have ever before occurred. The Canadian Hospital Council has a golden opportunity to be of material assistance in the working out of this program and its participation will be measured in large degree by the extent to which it will be given support.

The Sun Life Assurance Company of Canada has been a great friend to the hospitals through its assistance to the Canadian Hospital Council. For quite a number of years, by financing the Department of Hospital Service of the Canadian Medical Association, it was the sole support of the Council. In more recent years the hospital associations and conferences have been taking on an increasing share of this responsibility. In conformity with its long established policy, the Sun Life would now like to withdraw its contributions in order to aid some other young and worthy movement. Already sizeable reductions in the annual grant have been made and further amounts are to be deducted next year and the following year; with this policy we can take no exception. As this reduction in income occurs just at a time when it is highly desirable that the Council be expanding, rather than curtailing its activities, it is anticipated that the delegates to the Council meeting will spend some time working out a satisfactory solution.

Nursing Surveys in the Provinces

WITH the indefinite postponement of any national survey of the nursing situation, many people are asking what can be done to meet a condition which is bound to become worse year by year. At its last meeting, the executive committee of the Canadian Nurses' Association regretted the decision of the federal government to delay this national survey presumably because of a divided opinion among the provinces. At the same

meeting it was urged that there be a conference of the nurses appointed to provincial survey committees, with the hope that, in this way at least, some measure of co-ordination between the various provincial studies could be effected. Our latest information is that this effort to get unified action may also fail to materialize because of the desire of a number of the provinces to study the question independently. Provincial studies cannot be as effective as a national study but, at any rate, they are better than none at all. One or two of the provinces are planning really exhaustive surveys which may well serve as pilot studies, but it is most unfortunate that there cannot be some way of linking them together on a common basis.

Accurate Blood-Labelling and Patient-Identification Important

THREE incidents, occurring in western hospitals and related to the blood transfusion service inaugurated by the Canadian Red Cross Society, call attention to the absolute necessity for accurate blood-labelling and correct patient-identification on the part of hospital staffs and all individuals concerned with the collection of blood samples, with the testing and with subsequent blood therapy.

A blood sample received at the depot was found to be Group B, Rh positive. The requisition stated that this patient was Group A, Rh negative. An alert technician, noting the discrepancy, found that there were in the same ward two patients with the same surname, although the Christian names differed. In another hospital, two patients of identical surnames were in the same ward. Luckily the eventual recipient was found to be Group AB and, except for a transitory jaundice and lack of rise in haemoglobin level, no marked ill-effects resulted. In another case, on two occasions the patient was found to be Group A, Rh positive; a third requisition was found to be Group O, Rh negative. Re-checking with another specimen revealed the former Group A, Rh positive findings. A year or more ago an incident occurred where the result was most unfortunate. Of that case we have no details.

It is obvious that every precaution must be taken by all parties concerned if incorrect labelling or erroneous identification is to be avoided. One leading pathologist is of the opinion that the only absolute method of identification would be "dog-tagging" new patients upon admission, the tag to remain until their discharge. This identity disc should show his admission number, his surname, and his initials. One administrator has developed a thorough method of documentation. A chit is signed by the individual taking the blood sample, by an individual witnessing the taking of the blood, and the nurse in charge vouching for the identity of the patient. A similar documentation process is undertaken when the recipient receives the blood. The placing of an identification card at the foot of the bed, or numbering the bed, would not be adequate in the opinion of Red Cross officials because of the occasional transfer of patients. It is suggested that all technicians and nurses taking blood from a patient should adopt a rigid ritual in questioning the patient, checking not only on the surname but on the Christian name as well.

It is not good enough to ask "Are You Mr. (or Mrs.) ———?" In the case of a patient who is toxic, under sedatives, or otherwise confused, or who may not understand English well, it would be quite possible to get an affirmative answer or even an indefinite response which might be interpreted as an affimative answer. It would be much better for the technician to ask, "What is your full name please?" In addition, the patient's hospital number should also be checked.

As the provincial medical director in this province has stated, "Perhaps the long series of successful transfusions may tend to make laboratory workers regard whole blood with a certain lack of respect, but if it be brought to their attention that whole blood in many respects is a dangerous drug, I am sure the incidence of accidents due to technical causes will be kept to an absolute minimum".

Point Rating Helpful in A.C.S. Approval System

AT the regional meetings of the American College of Surgeons, much interest is being shown in the discussions on the point rating system now being followed by the College in its appraisal of hospitals. In the instance of the Western Canada regional conference, being held at Edmonton, practically the whole program was planned around this topic. Although the system is in operation, Dr. MacEachern has been anxious to obtain the opinions of those in the field with respect to the basis for awarding points and the weighting of these items. Reactions to date have been most favourable and a number of helpful suggestions have been obtained at these meetings.

The long view result of this method of appraisal should be good. The idea of standardization approval has probably been the greatest single factor in bringing about the vast improvement in medical organization and supervision in hospitals and in the development of more effective clinical procedures. However, having gained "approval," there is a tendency for hospitals and their medical staffs to rest on their laurels; for those improvements which are being effected from year to year in organization, standards, equipment, plant, personnel, et cetera, no means of giving credit or other recognition has been available.

Now, with the point system, the College has a much more sensitive indicator. There is little or no standing still; the hospital is either going ahead or slipping back. Its capabilities and achievements can be much more easily compared with other hospitals. And it can check its standing against itself, checking the current year's point analysis and total against a previous year. This system should prove much more stimulating that the former method. Quite a number of hospitals have obtained copies of the approval forms and are making their own analysis of their facilities. This is all to the good, particularly if it leads hospitals to take those steps which will mean improvement in their services.

Hospital Needs of the Community

"Natural boundaries and means of communication, rather than existing municipal lines, must be considered in setting up hospital areas."

Donald Cox, F.C.I.,
Secretary and Manager,
Winnipeg Municipal Hospitals,
Winnipeg, Manitoba.

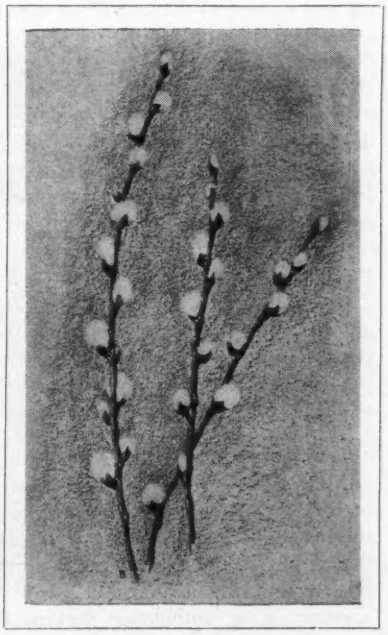
WHEN Cortez and his conquering armies stormed across the land of the Aztecs four centuries ago, they found the most advanced civilization in the New World on which to build their Empire. There were even native physicians and nurses, and doubtless, hospitals of a sort. Then Cortez realized the need for a real hospital service in his newly established community and, in 1524, he built in Mexico City, the Hospital of the Immaculate Conception, later renamed the Hospital of Jesus of Nazareth—the oldest existing hospital on this continent. In later years he endowed the hospital generously and charged his heir with the responsibility for its maintenance. Thus, the old conqueror, in his wisdom, recognized a basic community need—adequate hospital facilities, available alike to rich and poor, with the assurance of continuity throughout the years.

The requirements of hospitals have increased steadily with the advance of medicine, and the service offered by the Hospital of Jesus four centuries ago, excellent as it may have been, would be pitifully inadequate to-day. It is a fact, however, that the essential function of a hospital remains as it did in the time of Cortez. Briefly it is to care for the sick and injured and for that end all other possible activities should be subordinated. There is no actual difference in the type of hospitalization required by any individual or any community in this enlightened age. It is the right of all, regardless of race, colour, creed or station in life, to have available in time of sickness the finest hospital service that science and skill can provide.

The ability of the individual community to finance hospital construction, rather than actual needs, has frequently been a determining factor in the location of hospitals. Too often, to-day, patients remain at home because of the fear of overpowering medical and hospital bills. The Blue Cross and other plans have done much to spread the cost of hospital care but with the steady development of costly but essential diagnostic methods, it is obvious that nothing short of measures, either voluntary or governmental, which fully underwrite the cost of health services, will meet the express need and desire of a large percentage of our population.

Co-operation

While the essential need for a full and complete hospital service is common to all, it goes without saying that the method of bringing the service to the individual, or the individual to the service, must vary greatly between the urban community and the isolated rural districts.



If the waterways of the country are not traversed by a sufficient number of substantial bridges and ferries, makeshift and dangerous methods of crossing will be brought into use. Similarly, if the hospital facilities of a region are inadequate, and they are in every province in Canada, the gaps will be bridged by some type of haphazard care. It is becoming increasingly apparent that no community, large or small, can hope to be self-sufficient. McCauley's description of the far-off times of Horatius, *"Then none was for the party; then all were for the State; then the great man helped the poor, and the poor man loved the great;"* carries an important lesson in co-operation for the hospitals of to-day.

If the hospital needs of the community are to be truly met, it is essential that hospitals co-operate and, to some extent, pool their facilities in a way never previously accomplished. There are always those who scoff at co-operative efforts, but examples of their efficiency can be found in every community. To make possible a full measure of hospital co-operation, a master plan based on an accurate survey of community needs must first be evolved, with rural hospital districts radiating out from urban hospital centres. Natural boundaries and means of communication, rather than existing municipal lines, must be considered in setting up hospital areas. Local pride, so essential a part in a young and growing country such as ours, must not be allowed to interfere with basic hospitals where most needed. The various provincial governments have already made initial surveys and, in some instances, plans are well under way. Unfortunately, however, the hospital associations, despite their wealth of experience, have had only a

An address presented at the Western Canada Institute for Hospital Administrators and Trustees, October, 1948.

minor part in promoting and carrying out these surveys.

The Dominion health subsidies for hospital construction, announced late last Spring, are conditional upon an accurate appraisal of hospital requirements. This, in itself, will prove a definite incentive to provincial planning. Many pitfalls can be avoided if hospitals demonstrate their ability to work in close co-operation for the public good and insist that consideration be given to their views regarding the most efficient hospital systems for their respective provinces.

Group Medical Practice

Since the quality of service rendered by a hospital is largely conditional upon the ability of its professional staff, it is essential that the services of pathologists, radiologists, and consultants, be made available to district and rural hospitals. In smaller hospitals this can often be accomplished on a group basis with specialists spending specific days or part days at each of several hospitals.

District hospitals, if properly located, will usually serve an area that can support a specialized staff. At the Raiford Memorial Hospital in Franklin, Virginia, a determined effort was made to attract specialists to the community. It was found that this could best be accomplished on a guaranteed salary basis. Under this arrangement, medical and hospital services have been integrated to the extent that six salaried specialists operate a clinic on a joint budget with the hospital itself. Medical staff appointments are not confined to members of the clinic and a further seventeen doctors from the surrounding area enjoy staff privileges at the hospital.

In Lamont, Alberta, a group of six doctors operate a joint practice or clinic with offices in the Lamont General Hospital. The clinic conducts its own business affairs and pays the hospital for rent, heat, light, and other services. Diagnostic facilities are shared jointly by the clinic and the hospital. This arrangement facilitates visits of the doctor to the patient and the patient to the doctor. Consultations can be held whenever necessary without additional expense to the patient. Doctors are at hand at the hospital in case of emergency. Each doctor specializes in one phase of medicine and spends a major portion of his time in his speciality but all assume a share of the general office practice. This arrangement makes it possible to attract the services of doctors who would hesitate to establish a practice, i.e., an independent practice, in a town of 700 people. The members of the clinic are the only doctors in the immediate hospital area and they function as a closed medical staff.

While such measures of co-ordination might not be possible, or even desirable, in every community, they do serve as outstanding examples of successful co-operative effort to bring specialized medical care and adequate hospital facilities to the rural community. The large urban hospital must drastically revise the somewhat superior attitude at times encountered, and extend to the smaller hospital assistance in the form of special diagnostic services, technical advice and, wherever possible, opportunities to participate in the training of student nurses and interns. The small hospital, in turn, can reciprocate by aiding in student nurse recruitment and by serving as an important link in the public relations program of the large hospital; by a carefully planned distribution of hospital beds; and it can, in the greatest measure possible, bring the hospital to the patient. It does not solve the problem of bringing the patient to the hospital.

"The voluntary hospital must shortly be prepared to rest the case for its continued existence before the bar of public opinion. Hospitals themselves will have to demonstrate to the public that a properly co-ordinated system of voluntary, municipal and government hospitals can, in a land of free enterprise, render to the community a type of service which no form of bureaucratic control can hope to equal."

Transportation

Many thrilling stories of dramatic mercy flights have been written into the history of our great North West, but it rested with the province of Saskatchewan to inaugurate the first regular flying ambulance service in Canada. True, the aerial ambulance sometimes fails in its mission, as do all ambulances. Last July the Stork outdistanced the speeding 'plane and baby Dubril was safely born five thousand feet in the air above the Saskatchewan prairie. Doubtless at times the "Grim Reaper" dips his blade to take a harvest before the 'plane has reached its destination, but a record of 1,445 safely completed missions in thirty months is ample evidence of the efficiency of the project.

Although the need for emergency ambulance service to the isolated area is well known, the less spectacular need of the settled district is not so readily recognized. Yet you have all heard stories of injured people lying for lengthy periods on the streets, or of accident cases being bundled into waiting automobiles by well-meaning but unskilled bystanders, only to emerge with badly displaced fractures or damaged spinal cords. In many cities, police and fire departments provide emergency ambulance service and private firms handle non-emergent calls, either on a contract basis or independently, but the hospitals themselves often evince little or no interest in the actual transportation of the patient. On the other hand, in Cleveland, Ohio, the police department, working closely with the hospitals, operates a fleet of twenty-one ambulances equipped with two-way radio control, and provides coverage for the entire city for emergency and indigent cases. Except in emergency, calls are taken only through the hospitals. By mutual agreement, accident cases are taken to the nearest hospital. The hospitals agree to provide first aid care and make satisfactory arrangements for the treatment of all accident cases brought to them. The hospitals at first assigned interns to accompany the ambulances but discontinued that practice when the training of police personnel had been completed.

A somewhat similar ambulance department was recently organized by the Detroit police force in association with fifteen city hospitals.

Undoubtedly, in many districts, ambulance service is inadequate and, in others, non-existent. It would seem that hospitals have missed a great opportunity and a splendid pub-

(Concluded on page 70)

Trim Ten-Bed Hospital Achieved by Rural Community

OFFICIALLY opened in February, the new Fox Memorial hospital at Carberry, near Brandon, is one of the small hospitals now being erected throughout the rural districts of Manitoba. At the opening ceremony, when 700 visitors inspected the building, Hon. Ivan Schultz, minister of health, praised the community spirit which made the venture a success.

The one-storey hospital contains 2 private rooms, 4 semi-private, 2 children's cots, and 6 bassinets. On the first floor are the patients' rooms, nursery, operating room equipped for minor surgery, obstetrical, x-ray, and sterilizing rooms, and the laboratory. Living quarters for the superintendent, nurses, and caretakers, are on the ground floor. The kitchen, storerooms, laundry and drying room, are also located on this floor. A ramp for stretchers leads from the ground floor to the main floor.

The hospital is so constructed that additional floors may be built at a later date if necessary. There is a separate heating plant and both buildings are fireproofed, frame structures with stucco finish. The interior is plastered and painted—corridors in light green and cream, rooms in green, turquoise, peach and yellow. The nursery is finished in blue and pink with appropriate wall decorations. Ceilings in the operating room, obstetrical room, nursery, and corridors, are of sound proof donna cousta, and the floors are covered with marboleum throughout having a cream background with a mottled design. The call system is a combination of light and sound signals. Since there is no sewage disposal system in the town, septic tanks are used.

Details were carefully watched during construction and as a result there are numerous well-built, roomy cupboards, the lower section of each having a work bench with metaline or matching marboleum top. A nurses' desk, built of wood to specifications, has chart space and drawers enclosed.

Construction cost of the hospital was approximately $75,000 including equipment. Many individuals and organizations made substantial donations of both money and equipment. The ladies' aid played an active part in raising funds and supplying many articles such as linens, blankets, kitchen utensils, silverware (1881 Rogers), dishes, et cetera. A pantry shower resulted in completely filled shelves, and a tea served at the opening ceremony netted over $200. The sum of $40,000 was contributed by Mrs. Thomas Fox as a memorial to her late husband, a pioneer farmer of the district. Water and fruit juice glasses were purchased with pennies collected in bottles placed in various stores in town.

The staff is comprised of the superintendent, Miss Irene Oliver, Reg.N., one nurse, two practical nurses, and three ward aides. Dr. G. T. McNeill is the local physician and surgeon. Architects and contractors were Dring Brothers, Boissevain, Manitoba, and plans were approved by the government in accordance with the Manitoba Health Plan.

Main Floor Corridor

Effective Procedures for
Collecting Hospital Accounts

1. Arrangements with In-Patients

M. B. Wallace,
Treasurer,
Toronto Western Hospital,
Toronto.

IN an efficient admitting office, an intelligently completed admission questionnaire not only saves the time and steps of hospital staff but also offers the accounting office the effective tools for completing the financial job.

In some hospitals, the nurses may take the admission information at the bedside. In others, the forms may be completed by clerical staffs in a room, department, or area especially set aside for that purpose. The Toronto Western Hospital uses a combination of these two systems. Private and semi-private patients are sent directly to their assigned or reserved rooms where nurses complete the admission questionnaires. Public ward patients, however, come to the central admitting location. They are examined by a competent member of the intern staff and, if he feels that hospital admission is not necessary, other arrangements may be made. Sometimes relatives will strive to have elderly people admitted who do not require hospital care but need home nursing attention. Such examinations will eliminate a number of these cases and release beds for the critically ill. Examination on admission will allay the danger of having patients assigned to the wrong wards. The unnecessary work for nurses, extra linen used in transferring the patient, and a delay in commencing correct treatment may be avoided to a great degree by a check-up at the time of admission.

Billing Policy

It is the policy of many hospitals to have payment made for the first week's care at the time of admission. At the Western Hospital the patient's relatives are asked to visit the business office within two or three days of admission to make financial arrangements. Here we have a very definite policy of reviewing all accounts where no payments have been made during the first seven days. Ledger sheets are tabbed in order that all of Monday's admissions may be reviewed each Monday as long as the patient remains. On that day the Saturday and Sunday delinquent accounts are also checked; it could easily have been at our hospital that the term "blue Monday" originated.

The accounting office makes it a practice to call by telephone the next of kin or an immediate relative to discuss finances. If this method fails to bring satisfactory results, only then will the hospital resort to discussing the matter with the patient. Experience has proved that many times valuable information is added to a chart during the first two or three days of hospital stay. Often only skeleton details come to the business office on the admission form; later, names of friends or relatives may be added.

Part Played by Nurses

It is a good policy to be on friendly terms with the head nurse on each ward. It is helpful to talk over certain cases with the head nurses who know the patients' attitudes and outlooks. Many times I have been tipped off by a nurse to pay a casual bedside call as the long-sought and elusive relative had just arrived. While these approaches may not always assure you of the money, they usually let you know where you stand and give you some estimate of how to treat the case.

Sorting Cases

By methodically carrying out the above policy, the accounting office will be aided in getting in municipal order applications and in sorting out irregular and non-normal cases.

In-patient collections may also include Workmen's Compensation Board cases, Blue Cross, D.V.A., Indian Affairs, Lodges, County health schemes, commercial insurance, and the many others which may be peculiar to the community in which the hospital is located. The procedure presented here has been simplified and standardized.

Each morning a list of the previous day's admissions with addresses comes to the treasurer's desk. They are reviewed and passed along to the accountant and the chief clerk. Sometimes a case is spotted which has previously proved difficult; if the address looks suspicious, a quiet investigation is conducted.

There is no easy trick formula for a successful in-patient collection record. The main ingredient is continuous and persistent hard work. However, the points I have just made and which I shall briefly list again should help solve the perplexing problem of collecting bills.

1. Admission forms, with clear cut questions, should be intelligently completed.

2. If a payment is not required at the time of admission, the business office should come to a definite understanding with the patient or relative that payment will be made within a reasonable time.

3. Mail weekly bills promptly.

From addresses presented at the Ontario Hospital Ass'n. Convention, 1948.

4. When accounts reach a substantial amount or when they are overlooked for a long period, a regular follow-up phone call or letter will help.

5. See that billing of accounts to Blue Cross and the Workmen's Compensation Board are prompt and regular.

6. Co-operate with others and maintain a free and easy relationship with those who are in a position to help you.

7. Work hard.

* * * *

2. Collections after Patient is Discharged

Carl H. Merkel,
Accountant,
Ottawa Civic Hospital,
Ottawa.

WHEN settlement of an outstanding balance has been arranged and the patient is discharged, the collection set-up must start to function. If the account is settled as agreed its chores are light. All too frequently this is not the case, and we must press the delinquent debtor with all the means at our command to effect final settlement of the account.

Collection procedure may be divided into five phases:

1. The reminder—a statement or a mild notice wondering whether the account has been overlooked;

2. Discussion, if necessary, as to whether the debtor has a reason for not paying and if so what it is; try to arrive at an understanding in order to settle the account;

3. Appeal—not as in the commercial collection world to the debtor's sense of fair play, but through the fact that *we*, the hospital, have been very lenient and fair and now must *insist* upon payment or know the reason why;

4. Demand—a final notice that we can be patient only until such a date when we will have to resort to legal action;

5. Final action:
   (a) legal suit by hospital,
   (b) referring of account to professional collection agency.

Implementing the Five Phases of Collection

The simplest system is the use of a one-time carbon continuous form in as many parts as required. These can be used as the preliminary steps to special letters or procedures. The parts of this form, printed on various colours for identification, can coincide with the five phases of collections, i.e., statement of account, reminder, second reminder (if desired), past due notice, and final notice.

These notices are made up on the billing anniversary of the discharge and are filed alphabetically. All payments received or changes in the account must be posted to the "set". The forms should be mailed as the necessity is revealed by regular examinations of the accounts. The routine use of these forms can and should be altered to suit the occasion.

Telephone Calls and Telegrams

Much more can be discussed in a few moments on the telephone than by reams of correspondence and many things can be said which cannot be written. However, be sure to whom you are speaking and be careful of what information you can and do divulge. Telephone calls are more effective if made when the head of the household is available; the hour from 7 to 8 p.m. is ideal.

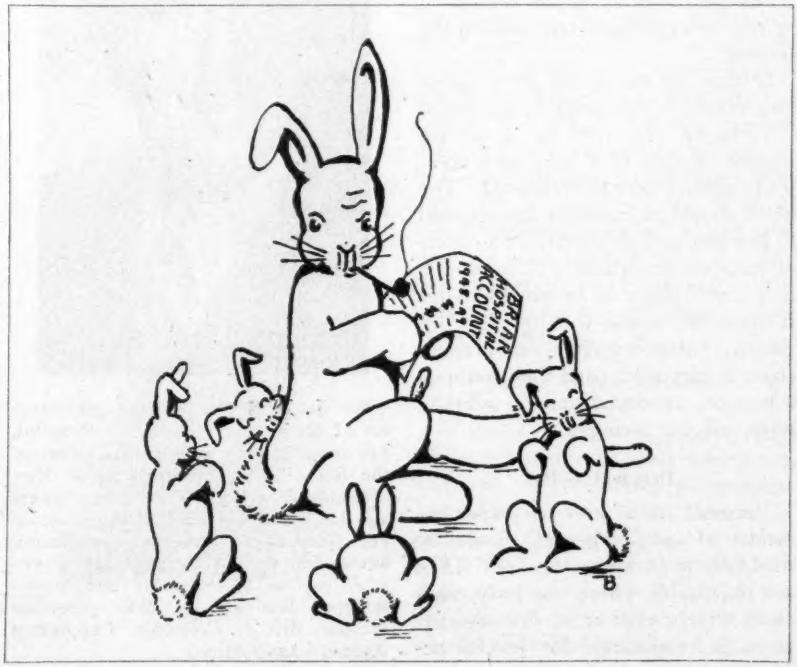
Telegrams as a routine collection method are too costly but they have a definite value as a fast means of notification where mail is refused, or phone messages ignored. Care should be exercised in phrasing telegrams of this semi-private nature, for the hospital must not leave itself open to a libel suit.

Form Letters

Printed or duplicated form letters are great time-savers but not good collection agents. No one letter can be drafted to cover the many situations which a collector meets. However, as a final notice or routine notification they serve the purpose and are economical. By using a *Collection Manual*, the hospital collector can vary his letters to suit the occasion and save much time. The manual consists of a series of form letters and standard paragraphs identified by number, outlining the common situations one might encounter. The party responsible can indicate by code on the account the letter to be sent.

Follow-Up

This is the most important set-up in a collection department. Promises to pay, due date of notes, et cetera, should be recorded in a day-to-day file so that if not met as arranged, a



reminder may be sent out. The system is simple. It consists of a day-to-day file where memos and copies of letters are filed by date. The accounts concerned are drawn daily by a junior clerk and presented to the responsible party for directions.

Newspaper reports of deaths, court judgments and legal notices should be checked daily. A death should be noted on the account and, after a suitable waiting period, the account mailed to the estate as claims must be established within a specified time to receive consideration. In court judgments, the plaintiff may receive an award and leave the hospital to whistle for its money while he goes on a spending spree.

In cases where a patient leaves hospital without arranging for settlement of the account, a letter should accompany the account, requesting payment in the course of a few days; this will prepare the way for future action should it become necessary.

Where a patient is allowed to leave hospital on the strength of a supposedly responsible third party who is later found to be not liable for the account, a letter should be sent advising the patient of the refusal of the third party to pay and asking for immediate payment. (Of course, it is much better to obtain payment on discharge, if possible, in all doubtful cases.)

Special Letters

The use of special letters is dictated by the circumstances surrounding the account.

It may be the result of a query to a notice, which must be answered accordingly. It may be a protest against charges or it may be a complaint against services rendered. The latter should be carefully investigated to preclude any possibility of a counter mal-practice claim. If in doubt, it is much better to ignore the letter if possible, cease billing for six months (after which a mal-practice claim is outlawed), and then continue action or, as circumstances warrant, write off the account.

Personal Calls

Personal calls are an expensive means of collecting and should be used only in exceptional cases. They are practicable where one body, such as an athletic club or service organization, is responsible for several accounts, or for making representation to insurance bodies, municipalities, children's aids, and other such groups.

An efficient outside collector can demand a good salary but it is extremely difficult for him to justify his salary in view of the fact that he is limited by time and other factors to only a few calls a day. On the other hand, low salaries may attract incompetent collectors, and incompetent staff members are very expensive. If none of the above means proves effective the hospital must resort either to the use of a commercial agency or court action.

Collection Agencies

Where a debtor cannot be located, it is preferable that the account be turned over to a professional collection agency. These agencies have the means, not available or financially feasible for us, to trace disappearing debtors. While they may have the psychological advantage of jeopardizing the debtor's credit rating elsewhere, they have no legal recourse that is not available to the hospital and their charges may run as high as 50 per cent of the account.

If it is necessary to choose a collection agency, be sure of its moral and financial responsibility. You do not want to lose the goodwill of the community because of the unethical actions of an unscrupulous collection agency nor do you want to find yourself having to sue your collector to recover payments on your accounts.

Court Action

To recover an account by court action, the first step is to establish the court in which to sue. In the Division Court an account up to $400 may be sued provided it is covered by a written acknowledgement of debt; otherwise the limit is $200. This shows the necessity of obtaining notes, liens, post-dated cheques, et cetera, on accounts—particularly those over $200. Accounts over $200 (or $400 if covered by written acknowledgement of debt) and not exceeding $800 must be sued in County Court. Accounts over $800 must be sued in the Provincial Supreme Court.

As those sued in the Division Court are in the vast majority, I shall deal with them and the procedure to be followed by the hospital suing on its own behalf. For cases in County and Supreme Courts, it is advisable to procure counsel.

The first step in the procedure is to obtain judgment. A claim showing particulars of the account is filed with the Division Court together with a cheque covering court charges. These charges vary with the amount of the account and are recoverable from the debtor if the action is successful, which is over 95 per cent of the time. Judgment is obtained in two ways: (1) by default, that is, no defence is entered within 8 days of notification by the court to the debtor of action taken, as the debtor acknowledges the debt; or (2) by trial, when the hospital must show the account is fair and just and the defendant is the person liable for payment. It may be pointed out that more than one party may be sued at the same time, e.g., husband and wife, parent and minor, debtor and guarantor, two municipalities, et cetera. The joint suit leaves to the discretion of the court the party or parties who are liable.

(Concluded on page 68)

L. F. C. Kirby Appointed to Direct Royal Columbian

Mr. L. F. C. Kirby, assistant director of the Vancouver General Hospital, has recently been appointed director of the Royal Columbian Hospital at New Westminster, B.C. Twenty-two years ago he joined the staff of the Vancouver General as assistant purchasing agent and since that time has served with various commissions and organizations, becoming in 1945, president of the British Columbia Purchasing Agents Association.

Meeting the Total Needs of
Long-Term Patients

Edna Nicholson, M.S.,
Director, Central Service for the Chronically Ill, Institute of Medicine, Chicago, Ill.

CHRONIC diseases now account for more than two-thirds of all deaths and for a considerable proportion of illness. Hence those who work in the field of chronic illness encounter problems related to the entire field of health and medical care. These problems are interwoven each with the other and no one segment can be solved except in relation to the whole. Our hospital beds cannot be used to their fullest effectiveness until they are supplemented by the other facilities and services in the community which are equally essential to meeting the total need for care of chronically ill people.

At the present time most communities do not make adequate provision for the varied types of care required by the chronically ill. As a result hospitals and other institutions are handicapped because they must carry part of the load of long-continued care of patients whose needs could be met at home—if they had homes. The hospital patient who has nowhere to go, except perhaps out on the hillside to die, must remain in the hospital. He will continue to remain there, whether we like it or not, until the sum total of community facilities for all types of care meets the total need. It is difficult, if not impossible, for the hospital to meet its responsibility to the chronically ill if it attempts to do so alone. To achieve this and to use its beds most effectively, the hospital must join with other interested professional groups in the community in studying the problems involved, planning their solution, and introducting such additional facilities and services as may be needed.

The community rightly looks to its hospital for care of sick people, for leadership in identifying new needs, and in stimulating planning and action to meet them. Until this planning and action have been productive, until facilities and services have been provided elsewhere for the care of chronically ill patients, there is grave doubt that much can be done to ensure maximum efficiency in the utilization of hospital beds.

Adapted from an address presented at the annual convention of the Ontario Hospital Association, Toronto, 1948.

Wide-spread Need for Planning and Action

During the past four years I have been in communities scattered from Ontario to Texas and from New York to California. Visitors have been in our office from England, Sweden, Australia, and Brazil. We have discussed the problems of chronic illness as they are encountered in the rural areas of Northern Michigan, in industrial centres, in mountain regions, and in rapidly growing metropolitan areas. Everywhere the problems are essentially the same: hundreds or thousands of helpless people are in need of care and the numbers are steadily increasing; there is widespread dissatisfaction with the kind and quality of care being provided in many of those institutions which already exist. Obviously an effective solution to the problem must include action on all three of these fronts:

1. Something must be done to decrease the number of people who become—and remain—helpless and in need of care;
2. Facilities must be provided to care for all who require it; and
3. Effective provision must be made to ensure that the care provided will be good care, both in existing institutions and agencies and in the new ones being developed.

It is essential that planning precede action and that both phases be co-ordinated into an effective attack on the whole problem. There can be no justification for the type of program which regards the increasing number of helpless invalids as a visitation of Providence to be accepted in a spirit of pious resignation and comfortable indifference. We cannot afford to build beds blindly and indefinitely for long-continued care of steadily increasing numbers of helpless people. Far too much of that has been done already. The urgent need now is for constructive action which will strike at the problem closer to its roots. Whenever we can we must prevent chronic illness and invalidism. When it cannot be prevented we must try to control the illness, prevent further disability, and rehabilitate the patient to the highest degree attainable. For those for whom prevention, control, and rehabilitation are no longer possible we must provide the best facilities and services we can to make their final weeks, months or years of life more bearable.

Edna Nicholson

Specific Points Requiring Consideration

Probably no one will disagree seriously with the ultimate objectives listed in the preceding paragraphs. The difficulty will lie in defining a program for practical action which will achieve these objectives. A clear understanding of the nature of the problem and its sources is essential. Factual information, including con-

sideration of the human elements involved, is vitally needed as a basis for determining the type and number of institutions and other facilities and services to be provided for persons in need of long-term care, the equipment and personnel required to operate them, and the ways in which they can be made available most effectively.

1. Relation to Research and Professional Education.

No one part of a program of this kind can be developed safely in isolation from the whole. Too often facilities for long-term care have been planned and developed as something totally apart from programs for medical research, professional education, and rehabilitation. The same people who are responsible for this short-sighted planning are too often the ones who complain most bitterly that no progress is being made in knowledge of the causes and methods of preventing or controlling chronic diseases.

We cannot have good care of patients without competent professional personnel to supply it and we cannot have competent personnel without adequate educational opportunities for them. These opportunities must include bed-side care of long-term patients as well as academic instruction. It is important, therefore, in planning the necessary facilities, to choose locations where they will be easily accessible for research and education as well as providing the best possible care for the patient.

2. Nature of the Problem and its Sources.

It is essential to clear up the confusion which continues to exist concerning the relationship between chronic illness and advancing age. We still hear comments made repeatedly about people who are helpless and must have considerable care merely because they are "old". Usually we are not very discriminating about what we term "old". Not long ago we had a call in our office for help in finding care for a patient who was unable to walk and required attention. We were told that there was "nothing wrong with her except that she was getting old and senile". The woman was fifty-four years of age.

The middle-aged or elderly person who is sick or disabled, or infirm if we care to use that terminology, is sick or disabled not because he has lived any magic number of years; he is helpless because his heart is in poor condition, his blood pressure too high, because he has diabetes, kidney trouble or cancer. He is not forgetful because he has lived fifty-four years, or sixty-four, or eighty-four, but because he has arteriosclerosis which is affecting the blood vessels in his brain. It is true that hearts are more apt to be in difficulty as the individual grows older; that cancer occurs more frequently in adults than in children; that kidney disorders, hypertension, and cerebal haemorrhages are more common in middle-aged and older people. It is important, however, that we do not confuse the relationship of age to illness.

I should like to emphasize this point strongly because I believe that it is confusion of this kind which is chiefly responsible for the tragic delay we have seen in any constructive efforts at prevention and control of chronic diseases and the invalidism which results from them. Obviously there is nothing which can be done to halt the passing of the years or to change anybody's age. Therefore, it would seem logical to many to do just what we have been doing, i.e., to accept chronic invalidism as an inevitable burden which should be borne with fortitude but which involves no responsibility on our part for contructive efforts to control it. It is to be hoped that humanitarian considerations will move us to a more constructive attitude soon.

Whether or not this occurs, however, grim necessity will force us to it in the not too distant future. The steadily rising load of infirmity and invalidism is well on the way to a point where the young adult population will no longer be able to support these increasing numbers of helpless people and, at the same time, carry the economic load involved in raising the children and maintaining the family.

3. Determination of Type and Number of Facilities and Services Required.

It is a mistake to set up arbitrary categories of people and to assume that all those in each category require the same care. Although such attempts are made frequently, in my experience they have been uniformly unsuccessful in accomplishing their original purposes. Efforts have been made to establish separate institutions for people who are "merely aged", for those "who have some ailment but are not ill", for "ambulant people", for the "semi-ambulant", or for the "bedridden". Many institutions of this type have been established but almost invariably, as they continue in operation, the lines of demarcation between their supposedly different types of residents become blurred. The institution established solely for people who were "merely aged" soon finds more and more of its residents becoming disabled and in need of care. Even those homes for the aged which have limited their admissions rigidly to older people known to be in good health at the time of admission have found that from 30 to 50 per cent of their residents must be given partial or complete bed care because of chronic illness.

It should be kept in mind that people rarely, if ever, enter an institution unless they are in need of some degree of protection and care. The amount of care which they need varies greatly from patient to patient

(Concluded on page 72)

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25 Years Ago

April, 1924

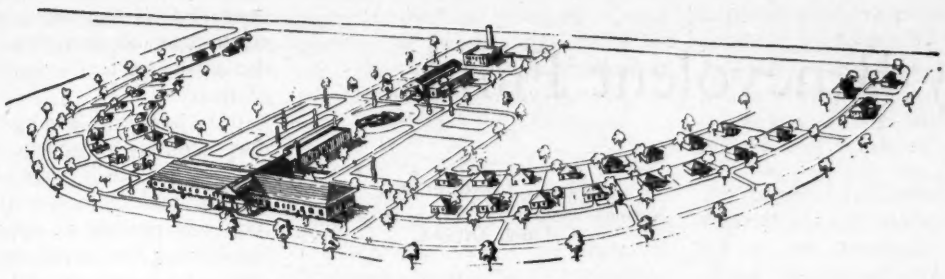
Dr. George F. Lewis, Deputy Fire Marshall of Ontario, contributed a strong article on the dangers of using nitro-cellulose x-ray films in hospitals. (This was several years before the disastrous fire at the Cleveland Clinic which aroused the whole hospital world to pass protecting regulations.)

James H. McVety was elected vice-chairman of the board of directors of the Vancouver General Hospital.

A new hospital was started by the Columbia Coast Mission at Alert Bay.

The Trades and Labour Council of Hamilton favoured the eight-hour day for the city hospitals.

A new hospital, l' Hôpital de l'Enfant Jésus, was being planned in Quebec City; it would accommodate 165 children and 20 maternity cases and cost about $200,000. ●



Model Institution

Designed to Provide

Homes for Aged People

TO assist the many municipalities now faced with the problem of erecting accommodation for an increasing number of indigent aged people, the Department of Public Welfare of the province of Ontario has worked out sketch plans of model institutions and is making them available to the public. Those shown on this page are among a number already released by the Honourable W. A. Goodfellow, Minister of Public Welfare. The province is prepared to pay 25 per cent of the cost of constructing such homes.

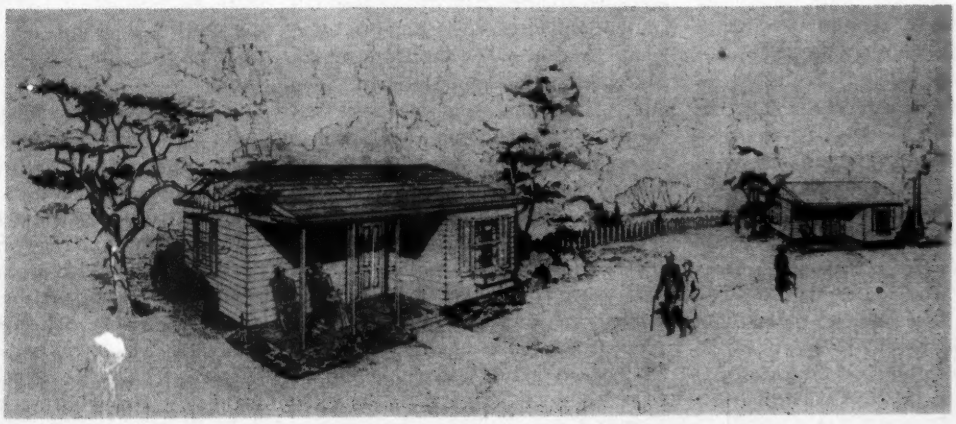
The proposed new institutions would not follow the old multi-storey design but would be composed of a group of one-storey structures (see illustration above). The main building in this design has separate wings for single men and women, with a large dining-room and service departments extending back to form the stem of a T-shaped structure. Directly behind the main building and connected with it by a tunnel is a large auditorium. Here there are a number of occupational therapy and handicraft rooms opening off the central assembly hall. A heating plant is in a separate building, beyond the auditorium. It is proposed to have lawns and gardens, with space for bowling greens and croquet on either side of the central building. Spreading out on both sides in a wide sweeping arc, as illustrated, are separate cottages, each containing a living-room, bedroom, kitchen and bath. A typical cottage is shown below.

The cottages would be used chiefly by elderly married couples and might, in certain cases, be leased at reasonable rentals to older people who are not indigent. If they wished, these people could prepare their own meals, purchasing supplies from the central stores department, or they might have their meals in the main dining-room. The attractive little dwellings should give at least a limited sense of independence to old people, a factor which in many cases is very important.

In the wings for single persons, no room would contain more than four beds since the old-fashioned dormitory type of room is no longer approved. Locker and lavatory facilities are centrally located in these wings and there are day rooms and balconies at either end.

Mr. B. W. Heise, deputy minister of public welfare, has indicated that, although not shown in the present plans, separate buildings to house bedridden and senile persons will be included.

Similar institutions for the care of the aged are now being designed in other countries. (See article September issue, page 39).



Army Benevolent Fund

H. C. Chadderton,
National Secretary, Army Benevolent Fund, Ottawa.

THE World War II Army veteran now has a Fund through which assistance can be requested to cover the cost of family emergencies which cannot be met through help from other sources.

This Fund, which represents nine million dollars built up by soldiers of the Canadian Army as canteen profits, has been available for the past eighteen months through D.V.A. on a temporary basis. The Act of Parliament which established the Fund specifies, however, that the administration will be centralized in the hands of an independent Board of citizen-veterans and such a board is now preparing to assume responsibility for the operation of the Fund. This board has no connection with the Government.

One of the major categories of distress in which the Fund is interested is medical expenses, including hospitalization. Consequently, persons connected with the administration of hospitals will be particularly interested in a review of the intent and purpose and administrative procedure of this Fund.

A word or two with regard to the Fund's responsibilities might be appreciated at this point. In the first place, army veterans are *not* entitled to assistance from this Fund as of right. It is true that all persons who served in the Canadian Army during the Second World War, and their dependents, are eligible to apply but the Fund can help only those who are the most deserving and in the most necessitous circumstances. The ratio will be about one in thirty-five.

It is generally known that the Department of Veterans Affairs provides treatment to veterans with overseas service and those who are pensioners under its Treatment Regulations. This board feels, therefore, that it cannot pay for medical service to veterans who are eligible to apply for D.V.A. care—and if the veteran is considered by that Department to be in sufficiently good financial circumstances to pay for his own treatment then that same decision will usually apply in so far as this Fund is concerned.

It is noteworthy that the Fund is of the "diminishing" type without revenue and although the total capital is in the neighbourhood of $9,000,000, this amount must last 50 years in accordance with the Act. Moreover, there are approximately 600,000 World War II army veterans and their dependents eligible to apply and because of the high percentage of army enlistments from low income brackets, it is reasonable to assume that there will be a large call upon the Fund's resources.

The Act specifies that all expenses will be paid out of the Fund and thus there is a great incentive to conserve administration costs. The Fund is therefore relying on independent welfare organizations, the Department of Veterans Affairs and Army Welfare Officers to carry out the greater part of its field work. Administrative offices are maintained in each province but such offices are limited in staff and have the responsibility for the entire provincial area.

Policy Regarding Payment for Services

Because of the large number of potential applicants, the board has adopted the policy that payment for all types of service, including hospitalization, will necessarily have to be at what might be called "welfare rates". Moreover, many applicants will be in effect "bankrupt" and therefore settlement of such accounts will have to be on the basis of "so much on the dollar" regardless of the rates for the service which has been rendered. This "bankruptcy" classification will apply to persons whose indebtedness is of such an extent as to be considered beyond the reach of the average low-income earner. It must be kept in mind that there will be more legitimate claims upon the Fund than there is money available to meet them and all that the board and its committees can attempt to do is render assistance to the most deserving of these.

It is hoped to develop the procedure whereby prospective applicants for assistance will come to the Fund *before* undergoing hospitalization. This will provide an opportunity of considering the merits of the applicant's circumstances and of making arrangements with hospitals *prior to treatment* so that there can be complete understanding as to the extent of the Fund's commitment. Such commitment would usually be at public ward rates.

Unfortunately, in our experience to date it has been found that many veterans and/or their dependents undergo hospitalization *first*, without giving thought as to how they can pay their bills. Then, when accounts are rendered, they realize that their financial resources are not sufficient and they apply to this Fund for help. It is realized that, in such cases, the veterans were at fault in that they requested admission without explaining that they would not be in a position to pay the resulting charges. In such cases the hospitals have provided the service (in some cases in private wards) on the understanding that the applicant would be in a position to meet normal costs arising therefrom. The hospitals are, of course, entitled to full payment but, nevertheless, the board has no alternative but to request that such accounts be at minimum charges before the Fund can assist in their payment. In summary, the situation is that the extent of the task facing the board is so large that unless this policy is pursued without exception it can be seen, in looking to the future, that many necessitous and greatly-deserving cases will have to go without the assistance of the Army Benevolent Fund.

Possibly this statement will seem odd; but nevertheless the board is of the opinion that its policy will be of benefit to creditors of army veterans. In actual fact most of the applicants to this Fund are in such financial state as to make it impossible for them to meet their indebtedness without our help. It is a certainty that if we do not assist them, hospitals could not expect payment without a struggle and considerable

wait, and might even have to "write off" the account (assuming, of course, that collection cannot be made from the municipality). Therefore, although this Fund cannot normally offer payment at regular rates, it can be realized that the Fund *will* provide delinquent veterans with a means of seeing that hospitals get some return for their service. Another consideration is the fact that when this Fund can save a hundred dollars on one case, this same hundred will eventually find its way into the bank account of another creditor because the Fund does not make payments direct to veterans. Consequently, all awards from the Fund are either for services rendered or for material items which the veterans require for their daily existence.

Requesting Reduction in Accounts

The usual method will be for the Fund to award a certain amount which it considers is the maximum that can be justified as an expenditure on the veteran's behalf. The definite stipulation is made that this amount

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Fonds de Secours aux Vétérans

IL existe, maintenant, un "Fonds de Secours" pour venir en aide aux familles de vétérans de la seconde guerre mondiale. Ce fonds représente la somme de neuf millions de dollars ($9,000,000) entièrement souscrite par les membres de l'armée canadienne, à même les profits réalisés dans les cantines. Il est administré depuis dix-huit (18) mois par le Département des Vétérans; toutefois, en vertu d'un acte du Parlement qui a établi le fonds, il sera plus tard administré par un Bureau indépendant composé de vétérans. Ce Bureau d'administration ne sera pas sous la tutelle du gouvernement.

L'aide additionnelle aux familles de vétérans se réflète principalement sur les frais médicaux d'hospitalisation, et autres. De ce fait, les Administrateurs d'hôpitaux seront très intéressés à en connaître le fonctionnement. Le fonds de secours n'est pas nécessairement accordé à tous les vétérans qui ont servi au cours de la seconde guerre mondiale, mais ne sera accordé qu'aux cas de nécessiteux, et dans certaines circonstances seulement, dans la proportion d'environ un vétéran sur trente-cinq.

Il est reconnu que le Département des Affaires des Vétérans prend à sa charge le traitement des vétérans qui ont fait du service outre-mer, ainsi qu'à ceux ayant droit à une pension militaire, etc. Evidemment, le fonds de secours ne s'étendra pas aux vétérans recevant déjà des allocations du Département des Affaires des Vétérans. Quoique la somme totale du fonds soit de près de neuf millions de dollars ($9,000,000), il est entendu qu'en vertu de la loi s'y rapportant, que la somme doit durer cinquante (50) ans. Les secours devront être distribués avec grande discrètion puisque 600,000 vétérans de la seconde guerre mondiale, y participeront, et sur ce nombre, comme l'enrôlement s'est fait principalement dans la classe des petits salariés, une assez forte proportion des vétérans devra y faire appel. Pour cette raison, l'administration des fonds devra se faire avec beaucoup d'économie dans les bureaux qui seront situés dans les différentes provinces du Dominion, et qui auront la responsabilité entière de leur province respective. De leur côté, les organisations hospitalières devront, de toute nécessité, hospitaliser les vétérans ayant droit de faire appel au fonds, dans la catégorie des patients publics, étant donné que ce genre de malades ne serait pas en position de payer lui-même son hospitalisation et traitements dans les hôpitaux. Il est prévu, à ce sujet, que les vétérans devront se présenter au contrôleur du fonds de secours avant leur demande d'admission dans les hôpitaux, en vue de prendre les arrangements financiers nécessaires avec l'hôpital où ils devront être hospitalisés. Par le passé la coutume était pour les vétérans de se faire hospitaliser, et par la suite transmettre leur demande d'assistance, accompagnée des comptes de l'hôpital qui les avait hospitalisés et traités, sans connaitre leur position financière. Dans bien des cas, le vétéran était hospitalisé en chambre privée et l'hôpital concerné qui l'avait accepté de bonne foi, devait faire une perte plus ou moins lourde.

Les conditions ci-haut mentionnées doivent être prises en considération, dans tous les cas sans exception, autrement des vétérans dans des conditions financières tout à fait pénibles, devront se voir refuser l'aide prévue par le fonds de secours.

Cette décision du Bureau d'administration peut sembler être quelque peu sévère; toutefois, il ne faut pas oublier que l'Administration doit faire face aux frais d'hospitalisation et de traitements, et ce, en toute justice pour les hôpitaux.

Nous tenons à souligner le fait, que les vétérans admis dans les hôpitaux, dans cette catégorie, ne sont pas en mesure de payer quoique ce soit, et que la proposition qui sera faite aux hôpitaux, par le fonds de secours, devra être acceptée pour le paiement intégral de la dette à être contractée par le vétéran; autrement le Comité de distribution du fonds se verra forçé de retirer son offre, et l'hôpital devra demander au vétéran d'acquitter son propre compte.

Procédures légales contre un vétéran

Il est convenu que le fonds de secours aux vétérans, n'assumera pas le paiement d'une dette contractée par un de ses membres, dans le cas où cette dette ne pourrait pas, légalement, être collectée à l'aide de procédures légales. Le fonds d'assistance aux vétérans doit être considéré comme aide auxiliaire aux vétérans, et la règlementation de son administration ou distribution spécifie que l'assistance ne doit pas être donnée aux vétérans pour d'autre fin que celle pour laquelle il a été établi.

Informations générales

La demande d'assistance aux vétérans de la seconde guerre mondiale participants au fonds, devra se faire directement aux officiers du Département des Affaires des Vétérans à la succursale la plus rapprochée. Dans le cas où les Administrateurs des hôpitaux désireraient connaître l'adresse du représentant local ou de son bureau provincial, ils n'auront qu'à en faire la demande.

Il est bien entendu, toutefois, que la demande de secours doit être faite par le vétéran lui-même. ●

A.H.A. Mid-Year Conference of Presidents and Secretaries

(The following is condensed from a report by Dr. F. W. Routley, secretary of the Ontario Hospital Association, to the hospitals of that association.)

THE mid-year Conference of Presidents and Secretaries of the American Hospital Association, which was held in Chicago in February, was attended by delegates from all state associations, with two or three exceptions, and also by representatives of tri-state associations and a number of city hospital councils. The very large attendance this year probably reflects concern over the possible socialization of health services in the United States within the near future.

At the first session, Mr. George Bugbee reviewed legislation affecting general hospitals in that country, showing that the trend is toward greater and greater control of these institutions by both state and federal governments. In the general discussion which followed, there was evidence that practically all hospital workers in the United States view with concern further legislation of this type, doubting that it will bring better working conditions in hospitals, better care of patients, or a more economical situation than now exists. Apparently, the Democratic party in the United States believes that the government should finance all health services through taxation, while the Republicans would build upon the present system and meet all charges for the care of indigents. Though Mr. Truman has repeatedly said that he will not interfere with the voluntary aspect of hospital service, hospital people still fear that there is a trend toward bureaucracy. However, one example of inefficiency in health administration was encouraging to representatives of voluntary institutions, i.e., U.S. medical and hospital services for veterans. A sub-committee of the Hoover Survey Committee, after a thorough investigation of the services for veterans, reported great extravagance, overlapping services, and over-building of hospitals. This report was most damaging to the arguments of those who favour all-over government control of health services. Keen interest was shown in Canadian experiments, i.e., in Saskatchewan and in British Columbia.

In summing up this discussion, it was agreed that Blue Cross has a definite place in the health field of the future and should be the voluntary agency for pre-paid hospital service, working in conjunction with state health departments.

A new plan, called the Ingle Plan, suggests that funds from government sources be made available to Blue Cross to meet the hospital expenses of indigents and also suggests treatment of veterans under Blue Cross in civilian hospitals. While the large labour unions in the United States appear to favour socialization of medical services, they are quite ready to back Blue Cross provided Blue Cross is always prepared to give complete hospital service to union members.

State Association Activities

Convention planning was a subject of keen discussion and it seems that a good many state associations do not hold annual conventions of the type known in Canada. Most of them have no planned general program and no exhibits. They hold a business meeting only and then send delegates to one of the tri-state conventions which are similar to our provincial conventions.

Local hospital councils are much more common in the United States than in Canada and are found even in small towns and rural areas. These are, to some extent at least, a responsibility of the general secretariate of the state associations.

Women's auxiliaries are not so numerous nor have they in the past played such an important role as they do in Canada. However, they are becoming more popular all the time and are being heartily welcomed in the hospital field.

Public Relations

It was felt that all state associations should have vigorous and active public relations departments and the matter of financing such branches was debated. California seems to be leading the way in that they ask member hospitals for a special contribution toward financing public relations, in addition to regular membership fees. They expect to have a public relations budget of $20,000 annually. It was the general opinion that hospitals have, on the whole, been lamentably slow about placing their case before the public and that this situation must be corrected as speedily as possible.

Opinion was unanimous that all state associations should have permanent offices, with paid secretarial staffs, enabling them to undertake services which have not been possible in the past.

It was emphasized that state associations have a heavy responsibility in the matter of maintaining high standards of hospital care, providing sufficient beds to meet the need, and in helping to avoid duplication of services in any given area. It was agreed that state associations must continue to place pressure on governments, both state and municipal, in order to obtain full remuneration for indigent care. In this respect most hospitals in Canada, though receiving only partial remuneration would seem to be more favourably placed than those in many of the States to the south.

State Associations and Blue Cross

As is well known, Blue Cross plans all across the continent have been promulgated, and their organization fostered, by state or provincial hospital associations. It has been revealed, however, that in the United States many Plans have become separated from their parent associations and in some cases are in conflict with them. Nevertheless, 68 per cent of the plans have a majority of hospital representatives on their boards of directors and a good many plans are actually operated by state associations. In the case of plans recently formed, associations are making very sure that they will retain complete control and often the secretary of the

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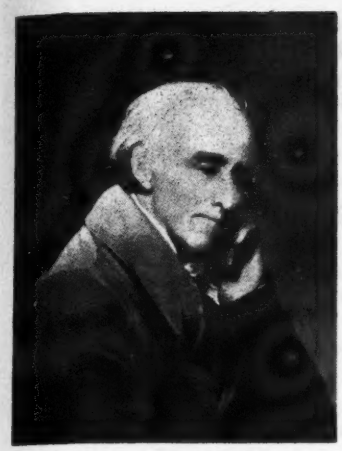


Benjamin Rush

Benjamin Rush—
Complete Physician

The Father of American Psychiatry

Clarence B. Farrar, M.D.
Toronto, Ontario.

WHEN the Pennsylvania Hospital, the first general hospital in the United States, opened its doors in 1756, Benjamin Rush, the most distinguished American physician of the 18th century, was ten years old. Actually, it was not the United States then. Philadelphia, the largest and most important city in the Colonies, was the centre of administration in the Province of Pennsylvania, one of the 13 colonies which 20 years later declared themselves to be the United States of America. Benjamin Franklin was mainly instrumental in establishing this first hospital, the petition to the Provincial Assembly for the erection of the institution having been drawn up by Franklin himself, in his own handwriting.

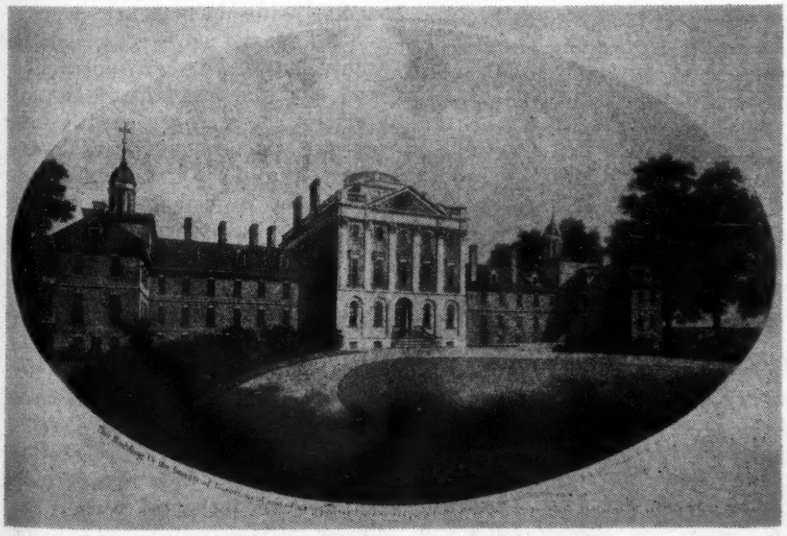
Benjamin Rush was born just outside the city of Philadelphia and at the age of 23, after two years' study in Edinburgh, we find him as the youngest professor in the first medical school in America—the College of Philadelphia, later the University of Pennsylvania.

As a member of the Continental Congress, Rush was one of the signers of the Declaration of Independence. During the first two years of the war he was active in the army medical service, personally attending the wounded at the battles of Trenton and Princeton. In the spring of 1777 he was appointed physician-general of the Middle Department. By introducing systematic inoculation against smallpox, he reduced the mortality rate among soldiers from somewhat over 15 per cent to less than 1 per cent. This was 17 years before the appearance of Jenner's paper on the safer procedure of vaccination.

After the war years Benjamin Rush resumed his teaching career in the College of Philadelphia, at the same time building up the largest medical practice in the city. In due course he was professor of medicine and head of the department.

It was more than coincidence when he joined the clinical and teaching staff of the Pennsylvania Hospital, the first general hospital in the United States.* It is important to note

Dr. Farrar, formerly Professor of Psychiatry at the University of Toronto, is Editor of the American Journal of Psychiatry.



The Pennsylvania Hospital in Rush's Time

This is the oldest existing hospital in the United States dating from 1751. The main building was completed in 1802 by the construction of the centre building. The East Wing (right) dated from 1756 and was used for medical cases with "lunatics" in the basement. In 1796 the West Wing (left) was erected for the care of mental patients only. In all, beds for 125 mental patients were provided. In 1841 mental cases were transferred to the new building in the suburbs.

**Not the first in North America. The first general hospital was apparently the Immaculate Conception, later the Jesus of Nazareth, founded by Cortez in Mexico City in 1524. However, the first hospital which is definitely known to have provided for both physically and mentally ill patients was the San Hipolito Hospital established in Mexico City in 1577. The Hotel Dieu de Precieux Sang, founded in Quebec City in 1639, was "for the care of indigent persons, the crippled and idiots".*

that this institution was in reality, as well as in name, a *general* hospital. It made no distinction between the physically and mentally ill as regards the admission and treatment of patients. When Rush joined the staff there were thus brought together the first *general*, i.e., complete, hospital in the United States and the first *complete* physician, i.e., one who in practise and teaching dealt with both physical and mental disorders and in every patient considered the whole man, not merely a part or an aspect of him.

At first, mental patients were confined in unsuitable basement rooms and, in his appeal to the board of managers for better accommodation for them, Rush expressed the conviction "that the patients afflicted by madness should be the first objects of the care of a physician of the Pennsylvania Hospital".

Although his first teaching appointment in 1769 was that of professor of chemistry (he wrote the first manual of chemistry in America, 1770) he was lecturing on general medical, including psychiatric, conditions virtually from the beginning of his career. There are preserved in various libraries in Philadelphia notebooks of Rush's students in which his lectures are recorded all showing the major attention given to morbid mental states. These notebooks date from 1771 to 1813, the year of Rush's death. In one of these, the most complete, 100 pages are devoted to diseases of the mind and 100 to all other diseases.

It was the observations of these forty and more years that Rush finally, at the age of 66, brought together in his textbook, *Medical Inquiries and Observations on Diseases of the Mind* (1812). The persistence of Rush's influence is indicated by the fact that this book was reprinted four times after the author's death, without the slightest alteration of text, the last time in 1835. Indeed it was not until 1883, in Spitzka's *Insanity*, that a rival textbook appeared.

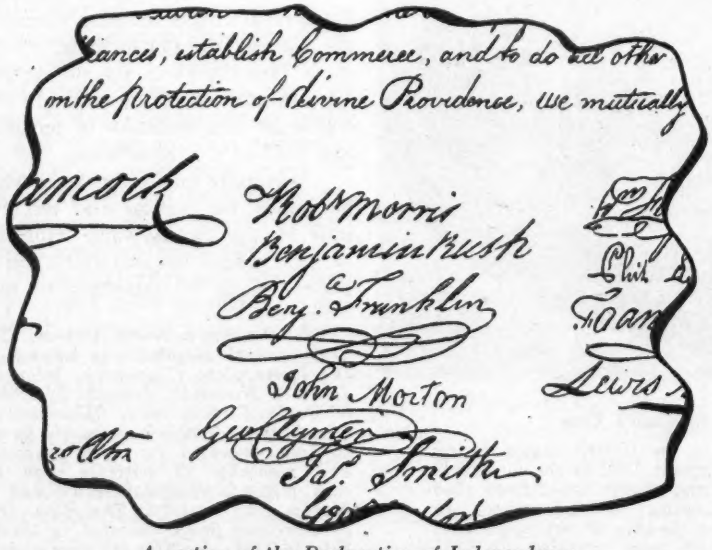
Benjamin Rush's attitude toward mental illness is reflected in the opening sentences of his book: "In entering upon the subject of the following Inquiries and Observations, I feel as if I were about to tread upon consecrated ground." He expresses the wish "that nothing hurtful to my fellow citizens may fall from my pen, and that this work may be the means of lessening a portion of some of the greatest evils of human life". In another place he writes: "The knowledge of the human mind is the most *important* branch of all the sciences . . . To a physician it is useful in an eminent degree, for the diseases of the mind are as certainly objects of medicine as those of the body."

But Rush does not discuss merely mental diseases in the commonly accepted sense; what is still more noteworthy is his directing his students' attention to the *psychological aspects of other diseases* as they come under consideration. Thus he emphasized, at the close of the 18th century, the "psychosomatic" (a term that should be superfluous) nature of illness more strongly than has generally been done even in this first half of the 20th.

This is not the place to discuss Rush's medical theories, which, while not out of keeping with the thinking of his time, were later abandoned; nor to criticize too severely his heroic bleeding and purging methods which other contemporary leaders in medicine also believed to be sound therapy. The very extravagance of these measures has tended to distract attention from his general treatment procedures, of great wisdom, in which he pioneered and which he consistently taught and practised. Rather we are here concerned with Benjamin Rush as one of a few great men, including notably the Tukes in England and Pinel in France, who at the turn of the 18th century ushered in the humanitarian movement in the care and treatment of the insane—a painfully slow movement against astounding social inertia and whose goal is still far off.

Rush was justifiably called the "Father of American Psychiatry," and in his devotion to this subject he stood alone on this continent. Yet he was not primarily a psychiatrist; that much may be said to his credit. He was the first clinician in the round. He did not bisect his human patients and treat them unilaterally. And with the handicap of lack of specific training, he gathered his experience through dealing with the general run of medical cases in both private and hospital practice, and in caring for the mental patients who formed part of a general hospital population.

Unfortunately, the interest that Rush felt so keenly and tried to stimulate in his students was not maintained by those who came later. In the words of Adolf Meyer, he had "no creative successor akin to his own spirit". In consequence, and perhaps owing in part to the theoretical aspects of Rush's teaching itself, psychiatry in America lagged behind that of Europe. And by the same token, it drifted away like a prodigal from its native environment in general medicine and lost caste as it did so. Only in the second half of the 19th century, and partic-



A section of the Declaration of Independence showing Dr. Rush's signature.

ularly in the last quarter of that century, did a livelier spirit manifest itself in progressive activities for hospitalization, treatment measures, and scientific study of mental disorders. Latterly psychiatry has been struggling painfully against many obstacles, partly of its own making, to recover its birthright. Only in the second quarter of the 20th century does an awakened insight on the part of both general medicine and psychiatry into their mutual need and dependence seem to offer some prospect of the happy consummation—an undivided medicine — envisioned by Dr. Benjamin Rush over a century and a half ago.

May 12th:

Make National Hospital Day Memorable in Your Community

OBSERVANCE of National Hospital Day has become a tradition among hospitals on this continent since its inception in the United States in 1921. May 12th, the birthday of Florence Nightingale, is one day of the year when hospitals have the opportunity to "advertise" their services, and no hospital, large or small, should fail to take advantage of it. We hear a good deal these days about public relations and winning community support; a wisely developed program, extending throughout the year and culminating on National Hospital Day, has great potential values.

Hospitals will observe May 12th in various ways, depending on size, location, and facilities. Even with the present-day pressure of work placed on busy administrative officials and the staff, it is worthwhile to mark this day in some manner, to make every effort to create a friendly, understanding spirit in your particular community. Enthusiasm must stem from within the hospital; the community will not be interested in you if you do not show that you are interested in it. It is well to keep in mind that Mr. and Mrs. Average Public probably never give a thought to the hospital until they have occasion to use its services. Then, when illness strikes, with possible consequent loss of time from work, additional expense and anxiety, resentment of such circumstances may counteract due appreciation and proper evaluation. Therefore, on National Hospital Day, when your doors are open to the public, a splendid opportunity is open to you. Here is the chance to educate the community in the value of the work you are doing, to let the people see how the various departments function, to show the expensive equipment which is essential and so gain understanding and support.

This year the federal grants to hospitals indicate even further expansion of services to the public. If you are planning any new developments, National Hospital Day is an ideal time to publicize your plans and to arouse community interest and co-operation. If you are making preparations for a sod turning ceremony or the opening of a new wing, addition, nurses' residence, et cetera, and if it is possible to hold such a ceremony on National Hospital Day, it will be all the more impressive.

The radio, press, clubs, schools, theatres, churches and allied organizations, posters, photographs—all are excellent media for advance publicity. And, of course, to give tangible assistance is that ever-willing and helpful group, the ladies' auxiliary.

The public will be much more amenable to increased hospital rates if it knows "Why?" It is not enough to let an all-inclusive statement concerning "higher costs" serve as an explanation. It would be well to display a chart showing a comparison of costs, present and past. This could include a cross-section of such items as food, linen, fuel, some items of equipment, et cetera. Patients when in hospital actually see very few of the entire personnel and may give little, if any, thought to the organization as a whole. As visitors on National Hospital Day they should be made aware of the staff required by the different departments — the medical records department, the laboratories, the dietary department, maintenance, and so on, including kitchen, laundry and cleaning help. Replacement of expensive equipment and supplies should also be explained and the fact that twenty-four hour a day service is given might be stressed. Housewives particularly will understand more readily if you point out, for instance, not only the frequency with which linen is changed, but the fact that it is in use day and night.

It may seem odd that hospitals, rendering so great a service to everyone, rich and poor alike, should have to educate these same people to the benefits they are receiving, and to win their support and co-operation. However, it is only through education and acquaintance with the aims of the hospitals that the public can be made to appreciate and value the services placed at its disposal. If public relations are extended throughout the year and a concerted effort made on National Hospital Day, your community will do more than just take the hospital for granted; it will give interested, active support, realizing that hospitals are established truly as a service to the community.—*E.S.*

Maritime Meetings Slated for Week of June 12th

Arrangements are well in hand for the annual convention of the Maritime Hospital Association which is scheduled to be held in the Nova Scotian Hotel, Halifax, on June 13, 14, and 15. This will be followed by a three-day institute for hospital administrators, June 16, 17, and 18, conducted jointly by the Association and the American College of Hospital Administrators. Mr. Ralph Gale, superintendent of Saint John General Hospital, is chairman of the committee in charge of preparations. Opening this week of meetings, the Maritime Conference of the Catholic Hospital Association will hold sessions on Sunday, June 12. The Maritime Hospital Auxiliary Association is also planning to meet concurrently with the hospital convention.

Teaching in a Hospital Pharmacy

F. D. Buck,
Chief Pharmacist,
Kingston General Hospital,
Kingston, Ontario.

THREE years ago when it became possible for hospital pharmacies to train apprentices for the study of pharmacy, it seemed like a very good idea to me. In the ensuing time this has been more than satisfactorily proved. From the first it has been an incentive to us to study and then pass that knowledge along to the apprentice.* We in the hospital pharmacy are never very far removed from our text books, brochures, pamphlets and professional literature. In fact, it seems that most of our spare time is devoted to reading and studying in order to keep up with the new products which, at the present time, seem to be coming on the market in deluge after deluge.

The work that an apprentice can accomplish in a hospital pharmacy is really amazing. In this particular case, the young man we chose as an apprentice had worked for us during two previous summers as a helper and porter, so he was thoroughly familiar with the general routine work and knew the stock quite well. When it came to the actual teaching of the branches of pharmacy, we found he was a very apt pupil, particularly in-so-far as the practical work went. He appeared to have a good grounding in mathematics, was neat and accurate in his work, and was not averse to studying. He depended a good deal on the written word and made voluminous notes.

To start with we insisted that in whatever preparation we manufactured, the background should be thoroughly studied, that is, each chemical or salt or vehicle that was used was to be studied that night by the apprentice and notes made regarding it. For this purpose he had, on his own initiative, purchased a BPC, Merck's Index, and Husa's *Pharmaceutical Dispensing* Vol. III. Then, the next time this preparation was made, a few questions on our part would soon tell whether or not he had a grasp of the composition of the prescription, and the general purpose for which the mixture was intended.

We were particularly pleased to note that he had an aptitude for the manufacturing of ointments, creams, lotions, and he turned out many fine products.

We have tried to keep abreast of the trend in the elixirs, vehicle and ointment bases, and we were very glad to have had the support of the medical staff in giving our attempts a fair trial. Most of these attempts have been successful and several of the bases and elixirs have become part of our standard formulae. We have derived considerable pleasure from our teaching—it has been fun to "set up" the distilling apparatus and manufacture 2000 cc. of "spirit ammonia aromatic" when needed. Several local apprentices were invited in to see the distilling apparatus. Then on two other occasions we invited them in when we were making suppositories using a 12 division mould; this time, as well as explaining the technique, we let them do the "heavy work" with mortar and pestle. We also had the pleasure of showing them how we made hydrophyllic ointment base USP XIII; likewise a special cream of which we use large quantities and for which special care and technique is required. Tinctures were made by maceration and percolation and by dilution from fluid extract (routine). We took every opportunity to show and instruct the apprentice in "the arts and mysteries pertaining to pharmacy" and we feel that it has been good for all concerned.

During the first two years, the apprentice was kept quite busy with the heavier manufacturing duties and, of course, the necessary stock work of a hospital pharmacy.

Large quantities of material are required to meet our manufacturing and stock demands. For example, ointments (that is the ointments that are used daily), are made in from one thousand to five thousand gram quantities. Our bulk powders (compounds) are, at the very least, made up in pounds. Suppositories are made up in batches of approximately seven dozen and capsules are usually filled in quantities of one hundred or more. In order to support this amount of manufacturing we buy most of our ingredients in large quantities. For example, mineral oil, vegetable oils, lysol, and base green soap, are bought in forty-five to fifty gallon drums, and our talcum, boric acid, and trisodium phosphate come in one hundred pound bags.

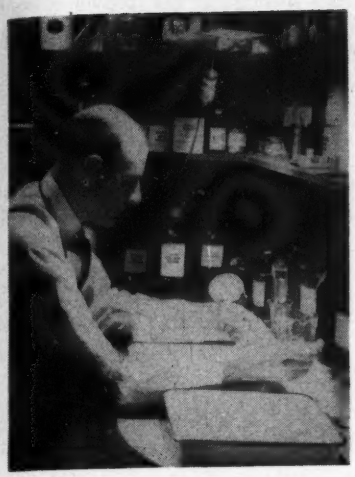
No Place for Weakling in a Hospital Pharmacy

From the above you will see that hospital pharmacy is no place for a weakling. However, last year the apprentice was switched to lighter work as he had become more acquainted with the prescription part of our duties. In the average day we fill approximately twenty prescriptions for patients leaving hospital, or specialists' clinics; also, under the university students' health insurance plan, we fill approximately ten prescriptions a day. Our house medical officer's prescriptions approximate five to ten a day, depending on the whims of the season. This does not include the number of prescriptions filled for the individual patient while in hospital. These are usually ordered on the chart order sheet and are filled in sufficient quantity to do each patient two days, as we feel that in this way we can cut down on the amount of medicine for which we do not have any use after the patient leaves the

(Concluded on page 88)

** In the province of Ontario, the training centre for pharmacists is the University of Toronto College of Pharmacy which has recently extended its course from two years to four. Length of apprenticeship has not yet been set but will probably be 18 months. This may be taken before or after the academic course, in any retail store or hospital directed by a licensed pharmacist.*

Adapted from "Canadian Pharmaceutical Journal," October, 1948.



Dr. Gaudry working in his specially built dark-room.

The Hobby Corner

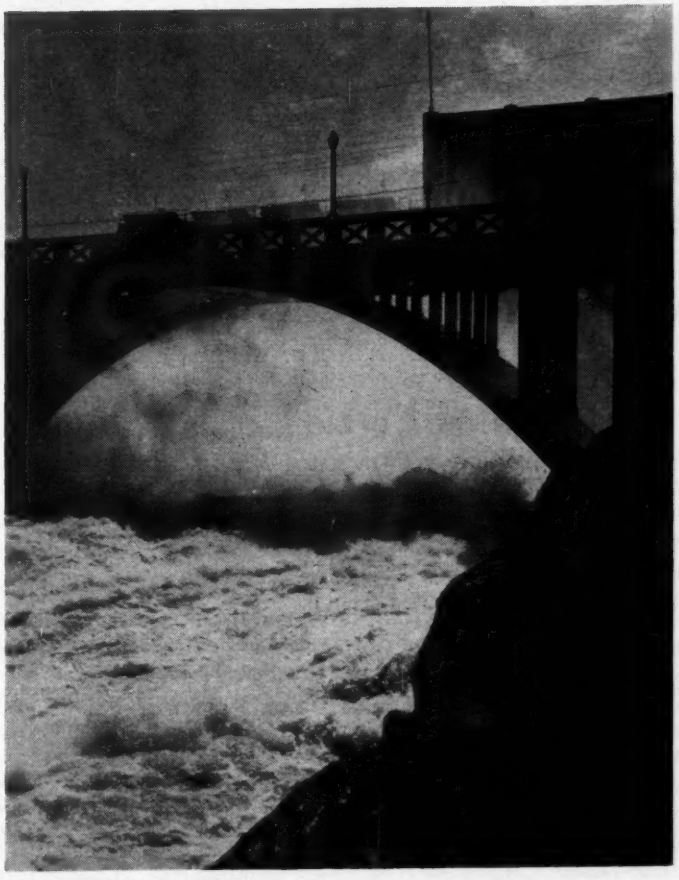
11. Dominique Gaudry, M.D.

IN the thriving city of Chicoutimi, at the junction of the Saguenay and Chicoutimi rivers in northern Quebec, a busy surgeon, Dr. Dominique Gaudry, finds relaxation in photography. The mighty Saguenay, rushing between steep high banks, is in itself a constant challenge to any artist, while the smaller river exhibits a most photogenic turbulence as shown in the accompanying picture. In this vicinity the rolling hills and innumerable other natural beauties provide endless variety in subject matter for the photographer.

Dr. Gaudry tells us that he first took up photography ten years ago. At that time he bought a Kodak "Retina" for the purpose of taking snapshots of his first child. He became so interested that when he built a new home a little later, he included a small dark-room for developing negatives and making his own prints. He now uses a Kodak "Medallist" and finds his hobby most absorbing "especially during the long winter months".

In his letter on this subject, Dr. Gaudry remarks, "It (photography) is such a vast field that for years one can enjoy acquiring experience and ability in it". Actually, for him it is more than a hobby, since he makes use of his talent and photographic equipment in both his clinical and hospital work. The Hôtel-Dieu St.Vallier at Chicoutimi is a general hospital with a capacity of approximately 400 beds, including a tuberculosis unit, and Dr. Gaudry is Chief of its surgical service. In this connection, he makes films of operations and slides for purposes of research and medical education. He has also used his pictures to illustrate a manual of surgical technique. This is a most valuable work and especially so since the hospital is a long distance from other large centres in the province.

Dr. Gaudry's salon pictures have been exhibited at Arvida and in Quebec City, as well as at the Canadian Medical Association salons in Winnipeg and Toronto.



This picture which is entitled "Les Grandes Eaux" shows the bridge over the Chicoutimi river in the city of Chicoutimi. It was a prize winner in the "Monochrome Section" at the C.M.A. salon last year.

Notes on Federal Grants

Arthritis and Rheumatism

Substantial financial aid from federal grants will go toward the work of the Canadian Arthritis and Rheumatism Society, which is now planning a nation-wide program of professional and public education on prevention, diagnosis and treatment. The Society is also promoting more adequate facilities for the cure of these ailments. The provinces are allotting at least one per cent of the federal grant available to them for general public health services to assist the Society.

Cancer

Federal funds for the Herbert Reddy Memorial Hospital, Westmount, Que., will purchase equipment needed in the treatment of cancer, including electrosurgical units for the treatment of skin cancer and short-wave diathermy apparatus for post-operative treatment.

Construction Projects

Beach Grove Hospital, near Charlottetown, P.E.I., will receive a grant of more than $85,000. The hospital will serve as an annex to Falconwood, the provincial mental hospital, and will provide 249 beds for the treatment of chronic mental cases.

Cobourg General Hospital, Cobourg, Ont., underwent alterations which increased its bed capacity to 32. Although the changes were completed last summer, the hospital was granted assistance from the federal government.

The new 36-bed West Lincoln Memorial Hospital, Grimsby, Ont., now under construction, has been declared eligible for federal aid.

Trenton Memorial Hospital, Trenton, Ont., will provide accommodation for 70 patients and serve a population of about 24,000 people. The federal share of the cost will amount to more than $58,000.

Three Hills Municipal Hospital, Three Hills, Alta., with a bed capacity of 29, will serve about 4,000 persons. As construction was begun before April, 1948, the hospital is eligible for only part of the usual federal grant.

St. George's Hospital, Alert Bay, B.C., in line for federal assistance of $31,000, was recently purchased from War Assets Corporation, moved by water to its present location, and altered for civilian needs. With a bed capacity of 48, it will serve about 7,000 whites and 1,500 Indians.

Alterations to the North Vancouver General Hospital will provide space for 10 more beds; the dominion government will contribute $6,600 towards the cost.

The Langley Memorial Hospital, Murrayville, B.C., will receive more than $33,500 in federal grants to help meet its construction costs. The new cottage-type hospital, with a capacity of 46 beds, serves a population of 22,000.

Fernie Memorial Hospital, Fernie, B.C., will have a capacity of 40 beds and the federal share of the cost will be approximately $40,000. The Royal Columbian Hospital, New Westminster, B.C. is being enlarged by an addition providing 189 new beds and has been assured of a federal grant of more than $140,000.

Mental Health

Funds from federal grants will provide additional staff and new equipment for the Saskatchewan Hospital, North Battleford, for the psychopathic unit of the Regina General Hospital, and for the Saskatchewan Mental Hospital and Training School at Weyburn.

Public Health

The federal government will pay the salaries of two nurses to work in the secondary schools of Saint John, N.B., city and county, and will make more widely available the services of dental clinics. Equipment will also be purchased for use by the public health nursing service in clinics for babies, pre-school and school-age children, and for health education.

Federal funds have been earmarked to hire two nutritionists to work in Saskatchewan's health units, and for a travelling dietitian to assist hospitals throughout the province. She will provide consultant service for those hospitals which do not have a dietitian on their staffs.

The University of British Columbia has been granted more than $27,000 to expand its teaching facilities in clinical psychology, bacteriology, and preventive medicine. Approximately $15,000 has been allocated for teaching equipment for specialized postgraduate training in clinical psychology, and $12,500 will be given to the department of bacteriology and preventive medicine.

Tuberculosis

The rehabilitation service, already in operation under the Manitoba Sanatorium Board, will be extended by the addition of another occupational therapist at Ninette, a teacher at St. Boniface Sanatorium, a teacher at the King Edward, and a social worker to deal with welfare problems of patients, ex-patients and their families. Another $4,000 has been earmarked to improve laboratory services at the King Edward Memorial Hospital.

The federal government has appropriated $35,000 to purchase and install x-ray equipment in Manitoba's large general hospitals for routine admission examinations.

In Ontario, 18 more hospitals are to be provided with x-ray equipment for routine admission examinations at a cost of $140,000. This is in addition to the $310,000 allocated earlier to the province's larger hospitals and will permit purchase of apparatus for all hospitals having 1,200 or more admissions annually.

X-ray equipment will be purchased for the Victoria General Hospital, Halifax, in order that admission chest examinations may be instituted.

More than $6,800 has been set aside to buy medical equipment for the Nova Scotia Sanatorium, and additional occupational therapy equipment. Salaries of two surgeons will also be paid; they will work in hospitals outside the Nova Scotia Sanatorium in an effort to improve surgical treatment of tuberculosis.

The Antituberculosis League of Montreal will receive a grant which will enable it to extend its program of mass x-ray surveys. X-raying about 160,000 persons last year, the

(Concluded on page 90)

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Food and Its Service

Sponsored by the Canadian Dietetic Association

Notes on Newer Dietary Equipment

Margaret Ketchen,
Director of Nutrition,
Toronto General Hospital.

SCHRAFFTS' dining-room in the Esso building of Rockefeller Centre, New York, has the most modern kitchen I have seen. The space is leased by Schraffts who operate a dining-room for outside patrons. They also feed employees of the Esso Company and are paid a 50 per cent subsidy. An average of 8,000 meals per day are served.

The kitchen walls are of pale green glazed tile and are completely soundproofed. There are no partitions, even for the dishwashing units. The floor is of "Marbloid" which is a terrazzo-like material applied one-half inch thick on a plastic base. It gives a non-skid resilient surface. Hoods over all stoves and dishwashers were straight sided, of stainless steel construction and were well lighted. Sumps under steamers and kettles were of stainless steel.

The refrigerators are made of stainless steel and all refrigerator doors have windows. The dumb waiters were likewise of stainless steel and had double doors.

As Schraffts' equipment was quite outstanding, I will list what I considered the most interesting.

"Lowerators" were used for all types of plates, and for racks of cups and saucers.

Urns are manufactured by Ershler and Krukin in Bayonne, New Jersey, and are Pyrex lined. They have a door in the side which allows the stainless steel coffee container to be put in. This seems to me to be a much better method than putting it in from the top.

"Thermolator" cabinets for hot food were made of combinations of electrically heated drawers. Shelves on which prepared food was placed to be picked up had radiant heating units over them.

The dish machines used are of "Faspray" manufacture. They have a pre-rinse compartment built into the machine. Racks for dishes are on shelves tilted toward the waitresses, and only one type of dish is put into each rack. Silver is put in round small perforated metal baskets and placed in a tumbler type silver washer. Cutlery must be dried.

"Cunningham" glass washers with a brush arrangement are used. Glasses are washed and rinsed in one compartment and sterilized in a second section. The latter process is automatic. To cut down dish breakage, plates are transported on dollies with rounded stainless steel partitions. Plates may be piled higher by using this method.

Items of equipment which were not familiar to me were an onion peeler manufactured by the Superior Peeling Machine Company, and a bean shredder put out by the Hobart Company.

A "Metal Wash" pot washer was installed, the first of its type I had seen. This looks like a medium-size dish washer, but the large volume of water used seems to cut down the labour usually involved in washing pots and pans.

The counter of the soda fountain in Schraffts has the floor level where the workers stand lower than that on which is the customers' seating accommodation. This means the employees are serving at ordinary working height and fatigue is reduced.

Notes from a report of a trip to New York and Boston in October, 1948, when Miss Ketchen visited a number of large hospitals and attended the annual meeting of the American Dietetic Association.

Columbia University

The "Watertown" plastic dishes have been in use in the cafeteria in Teacher's College for over a year and have been very satisfactory. Professor Mary de Garmo Bryan heartily recommends them. The surface scratches with continual use, and Professor Bryan says when the cups become too badly stained they are discarded. Even this makes them much cheaper to use than china. They use sauce dishes instead of saucers, as they think the former are too large for cafeteria service. At the convention of the American Dietetic Association, Boston, there was shown another type of plastic dish with the same base, "Melmac," but they were not as attractive as the "Watertown" plastic.

Radar Cooking

Professor Bryan seemed to feel that radar cooking will have its place in hospital food preparation. Foods which I saw cooked in this way and the approximate cooking time were:

Marmalade	**15 minutes**
Spanish rice	**15 minutes**
Baked Beans	**6 minutes**
Cereals	**1½ minutes**

Chocolate pudding was delicious as was lemon pie filling which took 2 minutes to cook. These products are never lumpy because cooking is done so quickly. Bread cannot be baked, (nor meats roasted) successfully by radar. Reheating foods for quick service will probably be a big feature of radar cooking. If these foods are only partially cooked before, the finished product will not be overdone.

The radar range at the Convention was four times as large as the one in use at Columbia University. All types of cooking were being demonstrated. A gingerbread muffin took 45 seconds, and it was light and fluffy. All cooking has to be done in glass containers.

New pieces of equipment are the "Radasear," a broiler, and an induction heater, a small unit which looks like a pyrex double-boiler. It seems to me this method of cooking will

(Concluded on page 68)

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With the Auxiliaries

The Little Shoppe at St. Joseph's, Victoria

In 1930 there was organized the first junior auxiliary to St. Joseph's Hospital, Victoria, the oldest hospital in British Columbia. With a membership averaging thirty-five enterprising young matrons and business girls, the auxiliary has to its credit an imposing list of achievements. Over the years, the auxiliary has purchased many essential items of equipment—oxygen tents, resuscitators, x-ray machine, operating table, and furnishings for the nursery—and, despite the inauguration this year of the hospital insurance scheme in that province, the assistance of such a voluntary organization is still in great demand.

Versatility and ingenuity have spelled success for the auxiliary's financial projects. It has sponsored the annual Spinsters Ball, the annual Baby Show for babies born at the hospital within the year, Christmas and Easter parties for children, and a mammoth Charity Auction. Recently, favourite recipes were collected and published in a unique and valuable book, *The Pot of Gold.*

In November, 1948, "The Little Shoppe" was opened—a permanent outlet for the beautiful handwork of the Sisters of the hospital and the auxiliary members. Hand-made babies' wear and children's dresses, religious articles, fine toiletries, stationery, and small gifts are stocked in an attractive setting. The Little Shoppe is served voluntarily by auxiliary members and patronesses during regular visiting hours. So successful has it proved that the auxiliary is looking forward to more spacious quarters in the new wing of the hospital, which is to be completed in the near future.

Windows of "The Little Shoppe", operated by the Junior Auxiliary of St. Joseph's Hospital, Victoria, display a fine variety of handworked clothing and small gifts. From left to right are: Mrs. R. G. Pearce, president, Mrs. J. W. LaCroix, Mrs. W. B. Simpson (in Shoppe), and Mrs. A. T. Satchwell, convenor of the Shoppe committee.

Position of Aids in B.C. Hospital Service Clarified

"In the development of our new hospital service there is one division . . . . that we are very anxious shall continue to take its proper place, and that is the service of the numerous women's auxiliaries throughout British Columbia. No hospital can develop its maximum of service without the assistance of a well-organized women's auxiliary. The comfort of our hospitals, the household equipment, and the community pride in our hospitals is as high as it is largely because of the support these auxiliaries have given to hospital boards in providing those things which are so necessary to the comfort of patients in hospitals.

"We must not let this interest relax. Some impression has gained ground that this service will not be necessary and that, if it is given, the value of the service will accrue to the hospital insurance service rather than to the local hospital. If the present arrangements with hospitals seem to indicate that this is the case, it will be corrected so that the value received from the efforts of the women's auxiliaries will accrue to the local hospital and the benefits to the local patients."—*Hon. G. S. Pearson.*

* * * *

High Income Average for Campbellton Aid

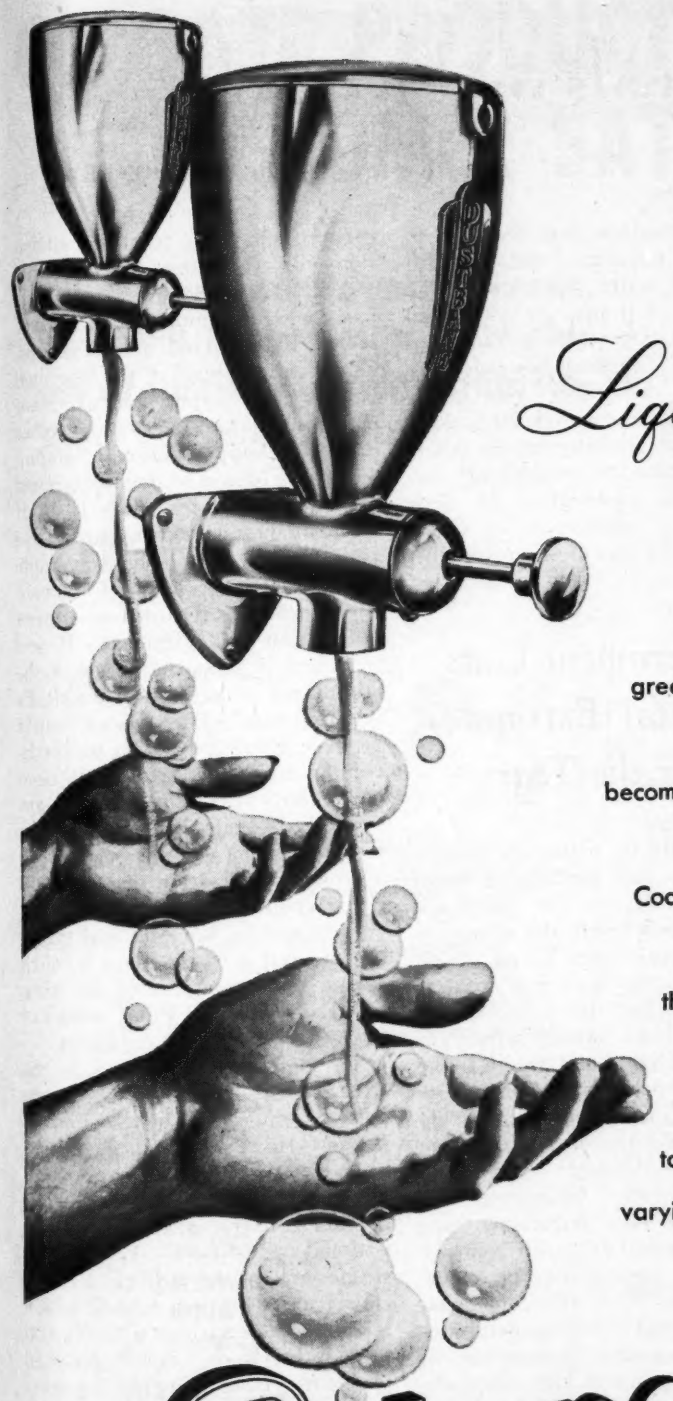
According to the 1948 report of the Ladies' Aid of Restigouche and Bay Chaleur Soldiers' Memorial Hospital, the average annual income of the auxiliary is approximately $6,000. From these funds, a considerable sum has been contributed to the building campaign and for the purchasing of equipment, such as an operating room table and screens for ward beds. The work of this aid is ably supported by an energetic group at Broadlands, P.Q., nearby.

* * * *

Chatham, N.B., Auxiliary Features Hope Chest

The Hotel Dieu Hospital Aid, Chatham, N.B., has hit upon a novel way to raise money for the hospital. A "hope chest", purchased and filled by the members, is being raffled off in the community. Tag days, food sales, Christmas stockings and Easter

(Concluded on page 94)



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KIND TO HANDS

D-B LIQUID TOILET SOAP removes grease, grime and dirt in a jiffy . . . yet hands never become chapped, red or sore. A pecial blend of highest-grade Cocoanut Oil and Cocoanut Olive Oils does the job — smoothly, thoroughly. Men like its powerful cleansing action — women workers like its gentleness to the skin. Four grades, of varying soap content, to meet your needs. Make a personal test. Get quotations and samples from the nearest branch of Dustbane Associated Companies — today!

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

At a time when the nation is straining every nerve to make the national accounts balance there is natural concern at the increase of expenditure required in nearly all departments. It was hoped that at least the defence services would not be making increased demands but the international situation is one which makes that inevitable as a precautionary measure.

When the Minister of Health came down to the House of Commons with a supplementary estimate to raise the amount for the health services from £150 to £208 millions there was a good deal of political criticism on the basis that there had been serious miscalculation. Mr. Churchill fulminated in his usual style and everyone expected a clash in the House, for which the government were quite ready to grant facilities. However, when the day came the whole thing had fizzled out and there was not even a division. What was worse, there was a very small attendance on either side of the House. The *débâcle* was regarded by the supporters of the Opposition as one of the reasons why their hopes in a by-election, pending at the time, were so disappointed.

As a consequence, the Minister has been obliged to tell the hospital authorities that their estimates for the coming year, which were on a still higher scale, must be reduced by £6 million on capital expenditure and £9½ million on maintenance expenditure. The teaching hospitals are particularly affected by these "cuts" for the simple reason that they have launched forth on a larger scale than other hospitals, especially those which were under the control of the local authorities. For anyone who has had occasion to follow the finances of both, the difference is quite remarkable. To some extent it may be attributed to the fact that at the beginning of the war the voluntary hospitals were given an assurance that their work should not suffer for lack of funds. The Treasury, in its generosity, permitted a method of paying for the reservation of beds likely to be required in an emergency, which was highly profitable. In addition, it must be admitted

Government Cuts Hospital Estimates for the Year

that it could be manipulated in a way which still further increased the advantage to the hospital's finances. As a result, the voluntary hospital committees found themselves with a financial security which they had never known before and a bank balance which enabled them to spend freely. The municipal hospitals had the check which the ratepayers inevitably exercise upon the expenditure and a well established system of budgetary control. Moreover, they had not the same inducement nor the opportunity to profit from the method of paying for the emergency beds. Since the conclusion of the war, the Ministry, being under the constant accusation of wanting to control the hospitals, have been particularly ready to agree to the proposals pressed upon them by the teaching hospitals. This has operated in a variety of different ways. For example, building licences were granted far more readily to the voluntary hospitals than could be allowed by the local authorities as they realized the claims upon the industry for housing and for schools.

The voluntary hospitals, which derive their funds from the allocations of the Regional Hospital Boards, can now be financed on a basis with the municipal hospitals, which are included in the groups. The men in control of the Regional Boards have experience of financial control and in many cases have good supporting teams among the finance officers of the management committees. But the whole basis of voluntary hospital finance, in so far as it had one, was something quite different. The possession of a substantial debt was regarded as a merit rather than a disadvantage. It was necessary if supporters were to be stimulated to meet the hospital's requirements. The money could be generally expected to be forthcoming to meet any special need particularly if it had a popular appeal. It is true that in the years just before the war there had been a growing realization that this was not a businesslike way of financing a great service but practical measures to put a check upon it, such as the gentle pressure of the King Edward's Hospital Fund, were not always received with cordiality.

To some extent, the key to the situation lies in the plea that the patients must not be allowed to suffer. However, that begs the main question—whether the extent to which "hospitalization" prevails in this country is wholly to the national advantage. Fortunately we possess, in the Nuffield Provincial Hospitals Trust, a body which is able and competent to study and pronounce upon these hospital problems. It has already inaugurated an investigation into the functions and designs of hospitals which should make a valuable contribution to an appreciation of their rightful place in the national health service. In the meantime, it is not too hopeful to express the view that this necessity for economy may lead to a searching examination from within of the working of the hospital service to ascer-

(Concluded on page 90)

COLGATE PRODUCTS GUARANTEE CUSTOMER SATISFACTION

Whatever your laundry needs, you'll fill them better from this list of uniform, quality guaranteed Colgate products.

GOLDEN XXX CHIPS AND POWDERED SOAP

A blend of pure fats, neutral and uniform, with special wetting and penetrating agents. Washes more thoroughly at moderate temperatures, rinses more easily and saves washing wear, saves hot water and fuel.

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A pure soap of low titre oils, Kwiksolv comes in quick-dissolving form for faster, safer washing. Blankets, all knitted things wash softer in Kwiksolv.

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A neutral synthetic detergent. Use ¼% solution—one cup to five gallons of water, hard or soft, any temperature. Especially valuable for washing in cold water acid solutions to protect fugitive colours.

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The heavy duty version of Arctic Syntex "M" . . . does a job on all types of laundry. Has high detergency . . . rug cleaners use one pound to forty gallons of water for shampooing finest orientals.

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Let your Colgate representative advise you how best to use the Colgate products specially designed to help you produce better laundry; or write, on your business letterhead, for Free Booklet and 40 gallon working sample. **Industrial Division 1-2 Palmolive, Toronto.**

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◂ Health Care Plans ▸

Quebec Blue Cross Benefits Over 9-Million Mark

At the 7th annual meeting of the Quebec Hospital Service Association held in Montreal recently it was reported that payment of $9,252,832.88 was paid by Blue Cross on behalf of the Quebec subscribers for hospitalization benefits and surgical and medical care. Although increased cost of hospitalization during the past year presented serious problems, a surplus of $9,174.97 resulted on the year's activities.

"It is encouraging", commented Mr. H. C. Hayes, chairman of the Board of Governors, "to see the widespread acceptance of and demand for Blue Cross services. Blue Cross is no longer an experiment. It is an established and practical plan whereby its subscribers may pay their own hospital and medical costs without looking to the state for assistance. It does not attempt to interfere with the relationships between the hospitals, the doctors and the patients. Its only aim is to enable the individual to provide for his own health services at the lowest possible cost on a voluntary basis."

Mr. E. D. Millican, executive director of the Association and Blue Cross Commissioner for Canada, stated "that enrolment figures for the year showed that more and more people of this Province desired to protect themselves against unexpected hospital and medical expenses through the Blue Cross method." As of January 1st, 1949, "409,576 persons were covered by the hospital contracts, 254,941 by surgical and 163,356 by medical contracts". He further stated that 77,647 new members had been added to the hospital services during the year, 93,069 to the surgical and 69,087 to the medical service.

Discharged from hospital during the year were 51,487 Blue Cross patients; 45.2 per cent were admitted to semi-private accommodation, 23.4 per cent to private, 19.9 per cent to standard ward, and 11.5 per cent were ambulant cases.

There were 19,824 surgical-medical claims paid on behalf of subscribers during the year. Since the inception of these plans on January 1st, 1947, $1,274,060.69 has been paid on behalf of subscribers.

Over 6,000 industrial firms and businesses in Quebec now make Blue Cross available to their employees and many of these firms are contributing a portion of the cost.

Officers elected to the Board of Governors were: Mr. René Morin, chairman; Mr. J. R. H. Robertson, vice-chairman; Mr. Ernest Charron, honorary treasurer; Mr. Edgar Genest, honorary secretary.

* * * *

Manitoba Blue Cross Marks Its 10th Anniversary

Writing its first membership certificate on the 1st of January, 1939, the Manitoba Blue Cross Plan has completed ten years of operation. Pioneering the Blue Cross movement in Canada, the Manitoba Plan was launched through the efforts of the late Dr. George F. Stephens and his group.

In that first year, the Plan paid hospital accounts aggregating $33,838; in 1948, the Plan covered hospital accounts of 39,789 patients at a cost of $1,634,186. In all, the hospitals received during the ten-year period $6,425,489 without loss, costs of collection or delay in settlement. Of the province's population, estimated at 750,000, the Plan claims a membership of 272,313.

The rising costs of hospital administration forced an increase in membership dues on the 1st of January this year. The general acceptance of these rates by the membership indicates their appreciation of the value of the pre-payment plan.

* * * *

Blue Cross Enrolment Growth Marked in 1948

Approximately 33,000,000 persons in the United States and Canada were enrolled in Blue Cross Hospital Service Plans at the close of 1948. Net growth for the calendar year 1948 was 3,686,879, bringing total enrolment to 32,997,161 on December 31.

Blue Cross now has over 21 per cent of the total United States population enrolled. In Canada, five Blue Cross Plans serving seven of the Dominion's provinces have enrolled 2,422,530 members, representing approximately 20 per cent of her population.

"Enrolment gains for 1948", declared Dr. Paul R. Hawley, chief executive officer of the Blue Cross Commission, "reflect continuing progress by Blue Cross plans toward fulfilling public demand for the provision of health service on a voluntary, community-sponsored, nonprofit basis of pre-payment."

* * * *

Ontario Government Votes Down Compulsory Hospitalization Plan

The Hon. Leslie Frost, provincial treasurer for Ontario, is quoted as saying in the House that the Ontario Government plans to initiate a prepaid subsidized hospitalization plan "some of these days" but that, because of the present shortage of bed accommodation, this is not the time. A C.C.F. amendment to the budget motion, which recommended immediate establishment of a plan similar to those in force in Saskatchewan and British Columbia, was defeated on a straight party vote of 45 to 34.

Cancer Film for Professional Audiences

Cancer: The Problem of Early Diagnosis, a new 30-minute, 16 mm. sound film in colour, is now available to hospital staffs, medical schools, and physicians and nurses. This film is the first in a series of six to be produced within the next two years and designed to constitute a teaching "package" on the subject of cancer. The first emphasizes the importance of early suspicion, accurate diagnosis, and effective treatment in cancer control, while the five succeeding films will deal in greater detail with diagnosis and treatment by specific body site.

The film may be purchased or borrowed and further information may be obtained from its sponsors, The American Cancer Society, 47 Beaver St., New York 4, N.Y., and the National Cancer Institute, U.S. Public Health Service, Bethesda 14, Maryland.

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NOW CONTAINS VITAMIN C

Now that Wyeth research has developed processing and packing technics that make it possible to stabilize ascorbic acid in milk products, *Vitamin C has been added to S.M.A.* So well fortified is S.M.A. that, when prepared according to directions, it provides a minimum of 60 mg. of ascorbic acid per quart for at least 24 hours. The S.M.A. formula closely approximates mother's milk . . . is well suited to modification for special feeding problems.

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Precautions to be Observed in Transfusing Patients with

Carcinoma, Nephritis, Leukemia and Anaemia

DOUBTLESS many technicians have at different times asked themselves this question: "Why did that patient have a reaction after I had re-checked the grouping, Rh, and the former cross-match of a bottle of blood?"

My own observations, over a period of six months, have led me to believe that the greatest number of reactions occurs with the following types of cases: carcinoma, nephritis, leukemia and anaemia.

In carcinoma, it frequently happens that patients of a specific group and Rh will have clumping in their cross-match with their own group and Rh. In one case, the patient was a strong A positive but had to be given O negative blood as this was the only group that would give a negative cross-match. If one places a few drops of the patient's cells on a slide on a warmed viewing box, one will note that there is very often an agglutination resembling Rh positive blood.

In nephritis, on doing a titration of the patient's serum in an equal dilution of saline with two drops of O positive cells in each tube, it will be noticed that in almost all cases you will find haemolysis of the cells.

It is advisable, therefore, to know the diagnosis of the patient before cross-matching as a cross-match that appears negative may cause a serious reaction.

In these cases the patient should not be given refrigerated blood. If a transfusion is necessary at night, there may be no alternative and, if the patient is under an anaesthetic, a reaction will seldom occur. Sometimes the physician is able to wait till morning and have blood freshly drawn and given at that time. A reaction is seldom noticed in cases where the blood is taken directly from the bleeding station, cross-matched and sent to the ward with instructions to be given immediately. If a reaction occurs, it is much lessened in severity. We have also suggested that the physician give a sedative about twenty minutes prior to the transfusion. At any time, the thought of having a needle in the vein is liable to cause apprehension, particularly in very nervous patients, and a sedative will quiet the fear. On occasion, too, it has been found advisable to divide the blood into 250 cc. lots.

Anne Milner,
Reg.N., M.T., R.T., (Canada),
Henry Ford Hospital,
Detroit, Mich.

If time permits, it is advisable to run the following tests:

1. Put a few drops of the patient's cells on a slide and note if there is clumping.
2. Warm agglutinin titer:
   (a) Serial dilution of the patient's serum in an equal amount of saline. Add two drops of O positive cells to each tube. Run titer from 1 to 128.
   (b) Incubate for one hour at 38° C.
   (c) At end of hour, centrifuge, take off supernatant fluid and add one drop of Bouine albumin to each tube.
   (d) Incubate again for forty-five minutes.
   (e) Read both macroscopically and microscopically.
3. Cold agglutinin titer: Repeat 2 (a), but instead of incubating place in refrigerator for one hour and then read both macroscopically and microscopically.

If these titers are both negative and the cross-match is negative, transfusion can be carried out.

One case was noted where the cross-match clumped, but on placing it in the water bath at 38° C. for two minutes it cleared and became negative. The cold agglutinin titer was negative at one hour. An effort was made to keep the blood at 38° C. during the transfusion. The physician in charge shone a light bulb on the bottle and reported that there was no reaction. The patient had been given a mild sedative twenty minutes before transfusion. This particular patient had previously had a series of reactions.

In the event that a patient has a cold agglutinin titer, it is wise to warn the nurse not to put the bottle in the refrigerator.

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We know that there are changes taking place in stored blood, and one of the best references, in my opinion, is *The Blood Bank and the Technique and Therapeutics of Transfusion* by Kilduffe and De Bakey, published by the C. V. Mosby Co., St. Louis, Mo. This is an excellent book for technicians as it deals with the practical phases of the work and discounts theory to a great extent.

From an article in "The Canadian Journal of Medical Technology", December, 1948.

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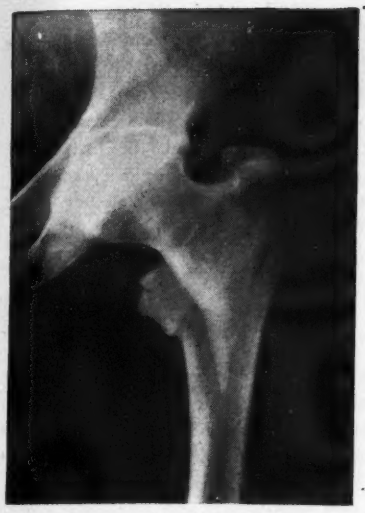

Fig. 1

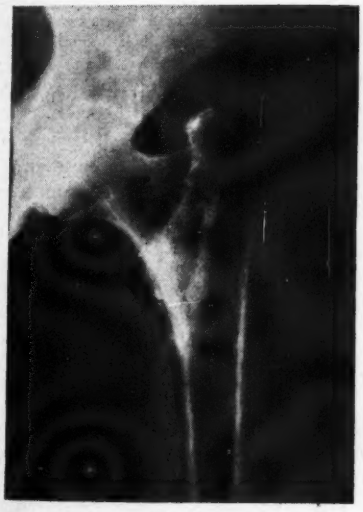

Fig. 2

Fig. 3

WELL-LEG TRACTION

Using Gypsona P.O.P. Bandages

March 6th.—Patient aged 66, sustained transtrochanteric fracture of the left femur. (Fig. 1.)

March 6th.—Fracture reduced and fixed in modification of the well-leg traction technique. Using Gypsona, a snug-fitting plaster casing was applied and anchored to the uninjured leg (Fig. 3). X-ray showed good reduction, which was maintained satisfactorily without need for any change of plaster during the two months in which it was retained.

April 30th.—X-ray examination showed good position and good callus formation proceeding (Fig. 2).

Comment. This method obviates the necessity for pins transfixing the heel or tibia, it enables the patient to sit up in bed, and thus materially reduces the risk of hypostatic pneumonia and pressure sores. It is essential that during fixation of the cross struts the injured leg is pulled, and the well-leg pushed, so that the top of the plaster is firm against the tuber ischii.

These details and illustrations are of an actual case. T. J. Smith & Nephew, Ltd., of Hull, manufacturers of Gypsona P.O.P. and Elastoplast bandages, publish this instance—typical of many—in which their products have been used with success.

Gypsona Plaster of Paris bandages are quick-setting and are ready for immediate use. They are supplied in 2", 3", 4", 6", 8" x 3 yds. Gypsona is also available in ready cut slabs.

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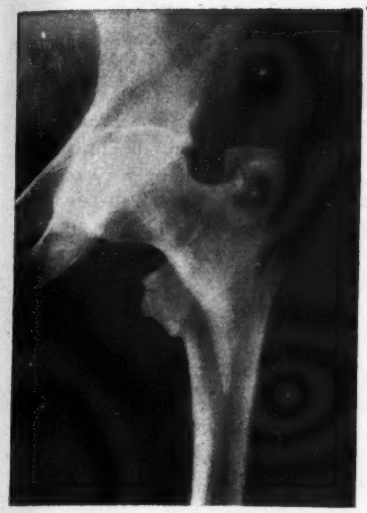

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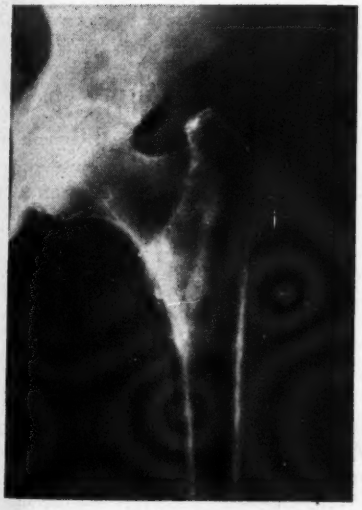

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Provincial Notes

New Brunswick

CHATHAM. Formerly a boarding school, Mount St. Joseph has been reconstructed and renovated into a hospital for the chronically ill and the aged. The large stone building, divided into public wards and private rooms, will accommodate about 105 patients.

* * * *

MONCTON. The board of trustees of the Moncton Hospital have accepted the property donated by D. A. MacBeath as a site for the new hospital. The firm ground, the fine view, and the high location make it suitable for building purposes. The offer of the land is contingent on the agreement that it be used within two years. The present hospital will be renovated for use as a nurses' residence.

In the meantime, numerous precautions have been taken to make the old building more fire resistant, including installation of a fireproof wall between the maternity ward and the new wing.

Quebec

HARRINGTON. The old hospital at Harrington Harbour has been officially condemned and work has commenced on a new 24-bed institution which will serve people along a 300-mile coastline, covered in summer by the launch *Northern Messenger*, and in winter by dog-sled. Designed by Ed. McNeil, a native of Labrador, the hospital will be fitted with a special wing for tuberculosis patients and will cost more than $200,000.

* * * *

MONTREAL. After more than 35 years' service, Miss Dora W. Miller has retired as lady superintendent (admitting officer) of the Homoeopathic Hospital. She joined the hospital staff in 1914 as night superintendent and became lady superintendent in 1935. During this period, she has seen the hospital grow from an institution for 50 patients to the new building, opened in 1927, which accommodates 122 adults and 22 babies.

* * * *

WESTMOUNT. A plaque was recently unveiled in the lobby of the Herbert Reddy Memorial Hospital, commemorating the life and work of Dr. Fraser Baillie Gurd, F.R.C.S. Dr. Gurd was the first chief surgeon and chairman of the medical board of that hospital.

Ontario

AURORA. The Ontario Government has bought the De La Salle Training School at Aurora and plans to convert it to a hospital for mentally defective children. Purchased for approximately $170,000, the school will be occupied at the completion of the college term this summer and will accommodate 250 patients. The main building, one residence, power house, laundry, barns, chicken house, a manual training building, and swimming pool, are located on the 115 acres of grounds.

* * * *

FORT WILLIAM. When it is completed, the new 120-bed wing of McKellar General Hospital will be named the Murray Wing. This decision has been made in recognition of a generous donation of $100,000 by Mrs. J. C. Murray a year ago.

* * * *

INGERSOLL. The cornerstone of the new Alexandra Hospital was laid at Ingersoll, culminating four years' work on the part of Oxford County citizens. The three and a half storey structure will be built at a cost of between $450,000 and $500,000 to provide accommodation for 60 adults and 16 infants. The federal government has approved a $61,000 grant.

OAKVILLE. Many people witnessed an impressive ceremony when the cornerstone was laid for the new 50-bed Oakville-Trafalgar Memorial Hospital. A copper box, made by students of the Oakville-Trafalgar High School, containing copies of Oakville and Toronto newspapers and current coins, was placed in the stone.

* * * *

TILLSONBURG. A new addition is planned for the Tillsonburg Soldiers' Memorial Hospital. The new $515,000 structure will provide accommodation for 76 patients, and the present building will be used as a nurses' residence and a 10-bed convalescent home.

* * * *

TORONTO. Excavation has commenced on the new $1,500,000 west pavilion at the Toronto East General and Orthopaedic Hospital. The seven-storey structure will add 200 beds to the present accommodation. Plans called for an addition every five years and there are still two wings to be built.

* * * *

WINDSOR. Plans for the construction of a 200-bed addition to the Metropolitan General Hospital have been approved. The total cost of the project is estimated at $1,400,000.

* * * *

WOODSTOCK. Miss Ethel Lamont has tendered her resignation as superintendent of nurses at the Woodstock General Hospital. Miss Helen Marsh, assistant superintendent and chief instructor of the training school, will carry on the duties of superintendent until an appointment can be made.

Manitoba

RESTON. It has been proposed that a nursing unit of ten beds be built at Reston this year. It is expected that grants from the dominion and provincial governments will amount to $2,000 per bed.

(Concluded on page 58)

THEY'RE X-RAY DETECTABLE —

They can't be "LOST"

For O.R. convenience — for *automatic* precaution — there is a widely distributed *rayable* monofilament insert in every Ray-Tec* Sponge and Ray-Tec Lap Pack which is clearly visible through the *heaviest bone structure.*

Reasons for the superiority of Ray-Tec are these:

Permanent — Remains detectable even after months in the abdominal cavity. Its *permanence* is due to the fact that the concentration of barium sulphate, U.S.P., used in the insert is an essential component of the insert material, specially processed — not merely a coating.

Surer, Simpler Detection — The Ray-Tec insert is readily detected on the X-ray plate by both experienced and non-experienced observers. The poorer the quality of the film, the more accurate this statement becomes.

The *wider* distribution of Ray-Tec inserts simplifies detection; permits less likelihood of being mistaken for body structures or artifacts.

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Years of research and experimentation with various substances have enabled Johnson & Johnson to perfect the Ray-Tec monofilament insert, thus providing a ready means of diagnosing the possibility of sponge or pack "loss" without exploratory laparotomy.

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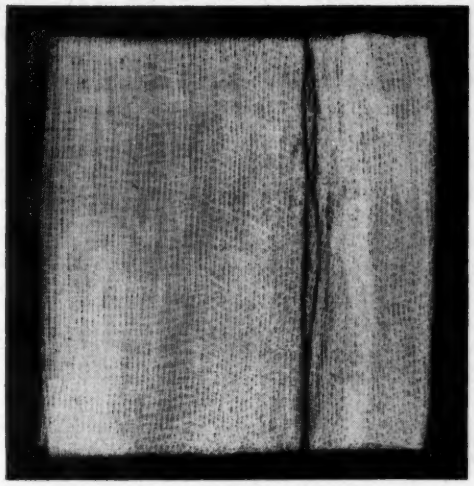
Made in Canada



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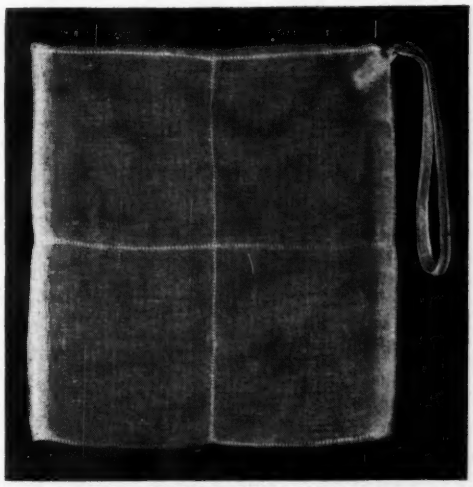
Insert is anchored across *full area* of sponge, making X-ray detection absolutely sure. No loose fibres to become detached and enter field of operation.

Insert is contrasting dark color; distinguishes Ray-Tec from regular gauze sponges.

SIZES

3″ x 3″, 12-ply
4″ x 4″, 8-ply
4″ x 4″, 12-ply
8″ x 4″, 12-ply



RAY-TEC LAP PACKS

Insert is stitched to narrow tape which, in turn, is stitched *full length* of looped tape (approximately 16″). "Burying" of insert protects it, permitting frequent launderings.

SIZES

12″ x 12″; 18″ x 18″; 18″ x 4″; 36″ x 8″
(28 x 24 mesh gauze, 4-ply; with looped tapes)

RAY-TEC SPONGES and LAP PACKS

Johnson & Johnson
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Saskatchewan

FOAM LAKE. After three years of planning, the new Foam Lake Union Hospital was opened on February 15. Built in a T-shape, the building contains three one-bed, five two-bed, and three four-bed wards, a children's ward, a nursery, and a four-bed isolation ward. Citizens of the hospital district generously donated furnishings and pieces of equipment. The cost of the 33-bed hospital was approximately $114,000 with grants amounting to $39,000 from the federal and provincial governments. The staff includes M. A. Williams, superintendent, and Mrs. Ethel Woods, Reg.N., director of nurses.

Alberta

CALGARY. The contract has been awarded for the construction of the new 365-bed Calgary General Hospital at an estimated cost of $2,876,003. Plans for the original 581-bed structure, without the two west wings, will be carried out. Construction will begin as soon as weather conditions permit.

* * * *

COLEMAN. Crow's Nest Pass Municipal Hospital, situated between Coleman and Blairmore, was officially opened in March. The 60-bed hospital will be staffed by 20 nurses and seven non-resident doctors from neighbouring towns. Under construction for almost two years, the costs have been boosted, by $90,000 over the original figure, to $275,000.

* * * *

HIGH RIVER. Miss D. G. Kearney, Reg.N., resigned last month as superintendent of nurses at High River Hospital. Miss Kearney has served as nursing superintendent for the past five and a half years.

* * * *

MEDICINE HAT. The Medicine Hat General Hospital has decided to close down its laundry, in view of the obsolete condition of the machinery and the soaring cost of new equipment. The work will be taken over by a private establishment, which will also absorb the hospital laundry staff.

LACOMBE. An estimated 1,000 persons recently attended the official public opening of an addition to the Lacombe and Community Hospital. The 27-bed wing boosts the total bed capacity of the hospital to 57.

* * * *

VEGREVILLE. At a cost of $50,000, an extensive addition to the nurses' home of the Vegreville General Hospital was recently completed. The old building was altered and reconditioned and the residence now accommodates 50 nurses.

British Columbia

COLQUITZ. The provincial government plans to commence construction of a new $4,425,000 mental hospital at Colquitz. The project will include an administration building with two wings accommodating 500 patients; a unit for dangerous patients with 100 beds; and a unit for disturbed patients with 200 beds. There will also be kitchens, a bake shop, dining-rooms, laundry, stores department, a boiler house, recreational therapy block, nurses' home, and farm buildings.

* * * *

VANCOUVER. The new surgical wing of Shaughnessy Hospital, opened in February, consists of seven operating rooms and associated workrooms, sterilizing, storage and dressing rooms. An important feature of the $250,000 unit is the observation gallery over the largest of the operating rooms, equipped with a two-way speaker.

* * * *

VERNON. An appeal, made by the Vernon Jubilee Hospital board of directors for assistance in furnishing wards in the new hospital, has met with generous response. All of the 10 private wards and many of the semi-private wards have been sponsored. Several organizations and individuals have also indicated a desire to assist in equipping various departments of the hospital. The committee in charge will recommend and purchase the equipment but will leave decisions regarding colour schemes and selection of furnishings to the sponsors.

VICTORIA. A start is soon to be made on construction of the main section of the new St. Joseph's Hospital. This new structure will be the centre portion of a V-shaped hospital which has been planned over three years. A smaller wing will also be built to accommodate from 25 to 30 patients. The latest estimate for the project is $2,500,000.

A.C.S. Holds Successful Regional Meetings

The regional meetings of the American College of Surgeons have been very successful again this year. Attendance has been excellent, taxing to the limit the accommodation in the convention hotels. Starting in the south, in January, subsequent meetings have been held farther north —in Buffalo in March, and in Butte, Montana, and Edmonton this month.

The Hospital Conference at the Buffalo meeting was well attended by Canadian delegates from Ontario and Quebec, although not as extensively as the merits of the program would have warranted. In addition to a 16-man forum on the point rating system conducted by Dr. MacEachern and Dr. Henry Farish, who had worked out many of the details when with the College, there were excellent addresses on relationships between hospitals, the general practitioner and hospital privileges, the medical audit, hospital costs, personnel training, and medical staff organization and control. Several new and excellent educational films were shown.

Among the Canadians participating were Dr. Robert I. Harris of Toronto, who addressed the surgical conference on the differential diagnosis and treatment of back pain; Miss Priscilla Campbell of Chatham, Ontario, and Mr. Gordon A. Friesen of Kitchener, who were collaborators at an evening round table conference in the hospital section, and Dr. Harvey Agnew who conducted the round table conference and gave an address on supervision and control of medical work in a hospital.

The Edmonton meeting, still to be held as we go to press, was planned as a "workshop" conference under the general direction of Dr. Angus McGugan.

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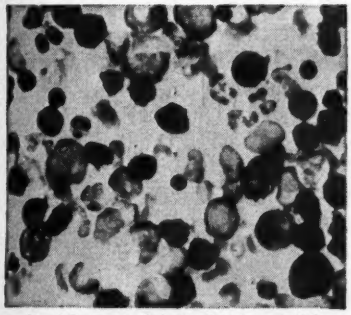
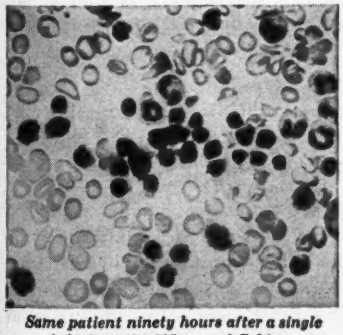


Pernicious anemia before treatment with Cobione (Megaloblastic Bone Marrow)



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FIRST isolated in the Merck Research Laboratories in 1948, clinical studies have demonstrated that Cobione* exhibits extremely high hematopoietic activity in the following conditions:

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In uncomplicated cases and those with neurologic involvement.
In patients sensitive to liver preparations.

★ **NUTRITIONAL MACROCYTIC ANEMIA**

★ **CERTAIN CASES OF MACROCYTIC ANEMIA OF INFANCY**

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Cobione* Possesses Significant Advantages

- It is a pure, crystalline compound of extremely high potency, and no known toxicity, when given in recommended dosage.
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*Cobione is the trade mark of Merck & Co., Inc. for its brand of Crystalline Vitamin B_{12}.

COBIONE

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Here and There

Embalming Methods in Ancient Egypt

THE Egyptian belief in immortality was profound and universal. In no other race have people so lived only to die. It was a purely physical immortality that was looked for and believed in. The belief doubtless had its origin in the almost perfect preservation of the bodies uncovered by jackals or by the shifting of the sands which covered the desert graves. Efforts were bent to preserve the bodies still more completely and gradually there developed an elaborate system of funerary rites. . . . .

The undertakers of those days were priests and the office was hereditary. They had no "parlours" but erected a booth or tent near the tomb and to this was borne the corpse. It was laid upon a table and stripped, after which an instrument was forced through the left nostril and into the brain which was then removed piecemeal. Next a long incision was made in the left side of the abdomen and through this were removed first the abdominal viscera and then the lungs. The heart was left *in situ*. Following this the body was doubled up and thrust into a jar of brine up to the neck. The head was covered with a resinous paste which prevented decomposition. The body lay thus for 70 days after which it was removed, washed and straightened. Little was now left save skin, bone and shrunken muscles, and this was put in a desiccating chamber where it remained until it was quite dry. In order to restore the fullness of the body, limbs and face, sand, mud or other packing was forced through incisions or pressed into cavities. Next melted resin was poured into and over the body until every crevice was filled. Then the cranium was packed with strips of resin-soaked linen and, after another application of resin, bandages were applied to the trunk and extremities. There were many swathings of bandages rendered adherent by the application of gum. During the process a priest recited chapters from the Book of the Dead and at appropriate times and places amulets were placed upon the mummy.

While the embalmers were busy, the tomb and coffin-cases were being prepared, the latter bearing over the face a portrait mask as accurate as possible. A great deal depended upon the mummy being recognizable. The encoffined mummy was next stood erect for the ceremony of the "opening of the mouth" which magically enabled the dead man to live, eat and drink in his new world. Following this the mummy was carried into his tomb. In the case of kings and nobles elaborate precautions were taken to hide the entrance and protect the tomb from robbers who, however, seldom failed to smell out gold and get possession of it. Of the hundreds of tombs which modern archeologists have discovered only one or two have been found intact and the vast riches stored in that of the young Pharaoh Tutankhamen is evidence of the enormous amount of gold, jewels, and other precious objects which must have filled the tomb of long-reigning kings such as Thotmes III or Rameses II for a Pharaoh's wealth was buried with him.

Excerpted from an article by J. C. Hossack, M.D., in the "Manitoba Medical Review", May, 1948.

Surgery Before Lister

The condition of the hospitals before the introduction of antisepsis will be best understood from the story of the experience of the well-known German surgeon, Nussbaum. He was the surgical director of the *Algemeines Krankenhaus* at Munich, the huge city hospital with some five thousand beds. At the end of the year 1869, he announced that he would no longer operate in that hospital. He had come to realize that conditions in it rendered operations so dangerous as to be unjustifiable. No wonder he refused to operate because the preceding year the mortality among his operative patients had been 79 plus per cent, that is to say four out of five of all his patients died. He was not to blame for this because the high mortality was due to the infected condition of the hospital. Erysipelas was practically always in the wards, and erysipelas, though now so seldom seen, was particularly fatal to surgical cases, and also to maternity cases. Erysipelas more than any other single disease brings about the development of childbed fever.

* * * *

The surgeons of the middle of the nineteenth century, as a rule, had not the faintest hint of any possibility of improving conditions in their profession. They felt they were at the highest point in surgical practice that could be reached. This fact is illustrated very well by a story that Lister told out of his own personal experience. When Lister asked Syme, whose assistant he had been for some years and who was then considered the greatest of British surgeons, for the hand of his daughter, his prospective father-in-law said to him that he thought it was too bad that Lister should be going into surgery just at that time when the outlook for any progress in surgery seemed quite dark. A man might make a good living as a surgeon but could not hope to make a great name for himself because he could only do what others had done before him, for surgery was at its apogee. The humour of the situation is that the great Scotch surgeon was making his lament of the lack of any future for surgery to the very man who was destined to revolutionize surgery more than any other man who had ever lived. As a result of his work a hundred times as many operations are done now as used to be done, and probably more than that. Lister's work was not only to revolutionize surgery but, above all, to revolutionize hospitals and nursing.

From "The History of Nursing", by James J. Walsh, M.D., Ph.D., published by P. J. Kenedy and Sons, New York.

Army Benevolent Fund

(Concluded from page 37)

must be the means of arriving at a *full settlement* of the indebtedness concerned, and all creditors are requested by the committee or agent to accept a share thereof. When a creditor indicates that he cannot agree to the proposed arrangements, the committee handling the transaction has no alternative but to withdraw its offer, and thus the veteran is left to handle the debt in any way he can.

The board considers it absolutely necessary to pursue this policy of minimum rates. It is realized that to make exception in individual cases, as such, might jeopardize the efficient operation of the Fund over the long term and no deviation can be made where creditors will not accept settlement—no matter how deserving the case may be.

Legal Proceedings

It might be of interest to know that the Fund cannot assist an applicant to meet a financial obligation which could *not* be collected through legal proceedings. In other words, if a veteran's account could be classed as uncollectable the Fund cannot assist in the payment of such for the reason that we would not be helping the applicant himself.

Fund is Auxiliary Service

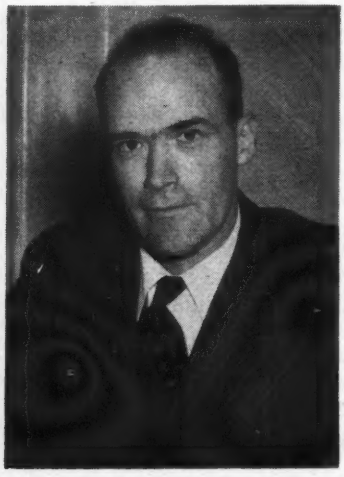
One point which the board stresses is the fact that the Fund is an "auxiliary" service. The regulations specify that assistance cannot be granted where such would be relieving a governmental or private agency of either its legal or moral responsibility. Moreover, the board is adamant that the Fund cannot assume the responsibility for emergency financial assistance to the entire body of army veterans who served in World War II. The Fund is ready to help but only as an extra source of aid and only if no other source of help is available. What the board is attempting to avoid is the development of the idea that the Army Fund should take over complete responsibility for army veterans which would leave other organizations with more financial resources to render welfare assistance to those civilians who are not entitled to the benefits of the Benevolent Fund.

Applications to this Fund will be made by the army veteran or his dependent, and must be submitted to a representative of D.V.A. or any agent, (i.e. certain branches of veterans' organizations and certain independent family welfare bureaus). Such applications are forwarded to the Secretary of the Provincial Committee of the Fund who is responsible for obtaining relative information and, if necessary, for making arrangements with regard to treatment or other service which might be necessary, and with regard to the settlement of accounts. In some cases, these arrangements might have been made through the person who accepted the original application, that is the official of D.V.A. or the agent, but normally all contacts with hospitals on behalf of the Fund will be made by the Committee Secretary who is a paid official and is authorized to represent the Fund in such transactions. These secretaries are being appointed and, should hospitals wish to secure the name of the secretary for their province, this information would be available at the nearest office of the D.V.A.

It will be seen that, in the ordinary case, it is the applicant himself who must come to the Fund. However, it can be realized that when a World War II army veteran or his dependent is encountering difficulty in meeting accounts for hospitalization the representatives of the hospitals will be concerned. Consequently, it is thought that in such cases the veteran should be advised by the hospital to contact the nearest representative of D.V.A. or any agent of the Fund with a view to determining whether or not it would be advisable to submit an application for assistance to this Fund.

It is realized that it will be both desirable and necessary for this Fund to co-operate in every possible way with the hospitals and all others who will be creditors of army veterans. It is hoped the necessity for the Fund's policy of rendering assistance at "welfare" rates will be realized and that over the years hospitals and this Fund can work together to assist the veteran and his dependents when they are not in a position to pay their hospitalization costs.

Business Administrator of Children's Hospital, Winnipeg



Mr. Allan McLean

Mr. McLean, who for the past three years has been Inspector of Hospital Accounting, Hospital Services Division of the British Columbia Government, was appointed in January to the position of business administrator of the Children's Hospital in Winnipeg. From 1936 until 1945 he was with the North Vancouver General Hospital and for the last five years of this period he was administrator of that hospital. In his new position, Mr. McLean is already proving his ability, according to a comment by Dr. Wallace Grant, superintendent of the Children's Hospital. It is expected that he will not only consolidate the business affairs of this hospital but will assist materially in planning for the new building which is to be constructed in the medical centre area of Winnipeg.

"Peep-Show" Hearing Tests

The Glasgow Ear, Nose, and Throat Hospital has installed new equipment to test the reaction of small children to sounds as a test on degrees of deafness. This replaces the normal adult audiometer machine which requires a degree of co-operation between patient and doctor. The new "peep-show" equipment gives an automatic reaction, since the child responds to sounds by pressing a button which, in turn, brings nursery animals into view. The fact of automatic reaction to varying intensities of tone and sound allows the staff to assess accurately the hearing ability of the child. By this method it has become possible to ensure a very accurate degree of testing, while the child shows greatly increased co-operation. — *Hospital and Health Management, Feb., 1949.*

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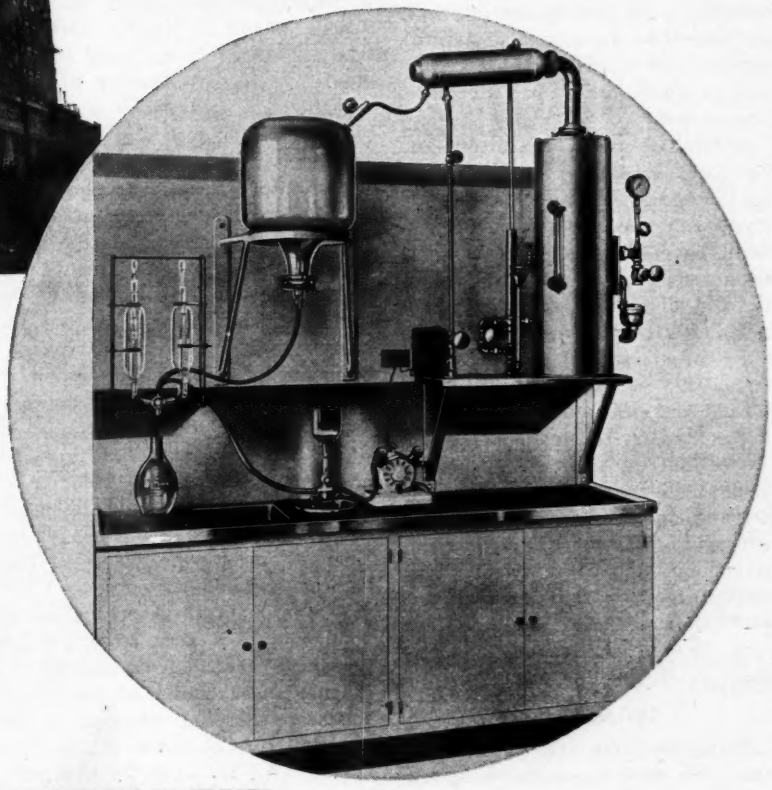

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Hospital Dietetics in Britain

Winifred Pegram

DURING recent years, hospitals in Britain have made great strides in the preparation and serving of food both for patients and staff. Formerly the responsibility for catering arrangements was shared by the secretary, steward, matron, and a sister house-keeper, each of whom already had a comprehensive task.

Britain's Ministry of Health and the King Edward's Hospital Fund for London, working in close co-operation with the government department, have done excellent work in helping to improve the standard of diet for all sections of the hospitals including patients, medical, nursing and domestic staffs. From September, 1939, to February, 1944, the difficult years of World War II, one of the Ministry of Health's dietitians carried out an intensive survey of hospital diets, covering hospitals in England and Wales. The collected information has been of great value in enabling the Ministry to advise hospital catering staffs and appoint qualified personnel to buy food and stores to the best advantage and plan meals of the highest nutritive value.

Divided Duties

The Ministry of Health is responsible for the provincial hospitals, while the King Edward's Fund for London, as its name implies, sends visitors in an advisory capacity to help in the hospitals of Greater London.

The first step taken towards effecting improvements was the appointment of catering officers. They are responsible for every branch of catering, including the buying of all stocks in bulk, the preparation of menus, the cooking and serving of meals in conjunction with the chef and kitchen staff, and the planning of diets with the hospital dietitians.

A survey of some of London's largest hospitals has provided some interesting data on the way in which the catering officers, or nutrition experts, are dealing with the problems of feeding everyone under their care, despite labour difficulties, rationing, shortages of every kind, and constant reference to the Ministry of Food and the local food office.

There is complete fairness with regard to sharing rationed and unrationed foods, especially those more appetizing items in short supply, as the catering officer guards the interests of staff as well as patients.

The main meal is served in the middle of the day for patients and nurses. When the meal includes roast meat, which cannot be served very often, it is given to the doctors and sisters for the evening meal in order that they may have time to enjoy it. The catering officer at St. Thomas's Hospital, London, the great block that lies on the banks of the Thames, opposite the Houses of Parliament, has another reason for serving the main meal at night. Its visiting staff is very large and for these workers no main rations are drawn; snack meals of unrationed foods are therefore provided so that the staff's rations will not be consumed. All hospitals, like domestic homes, work primarily on the basic rations, which are constant, and are drawn for each in-patient and resident member of the staff.

Detailed Forms

Added to these basic rations, there is an allowance for any meal served to members of the visiting staff which is comparable to that served by an ordinary industrial canteen. This allowance varies and detailed forms showing the number of hot drinks, luncheons, teas, and snack meals served during a rationing period have to be filled in by the catering officers and returned to the local food office.

Then, there is an occasional allowance of cooking fat which enables the chef to serve a favourite meal more frequently, i.e., fish and chips, which is enjoyed by patients and staff alike. To fill in the gaps after the rations have been used, unrationed foods (among them fish) must be found. This has been increasingly difficult with the dearth of many tinned meats formerly purchased from the United States.

However, there are available from time to time varying quantities of poultry, game and offal, such as sweetbreads, liver, hearts, oxtails and tripe. With regard to poultry and game, hospitals have the advantage over the housewife since the catering officer is able to buy in bulk, at the source, many of these foods which are in short supply. Another advantage is that the very small supplies of dried milk are directed to the hospitals and clinics, as are those small quantities of frozen eggs which are not available to the general public but which are invaluable in maintaining the necessary standard of protein foods. In St. Thomas's Hospital, tinned and dried milk is used exclusively for cooking, leaving the fresh milk for drinking and for serving in tea. The dairy in this large establishment presents a pathetic sight now with its sparse crates of milk bottles. Before the War, 200 gallons of milk per day were used; now it is fortunate if 500 gallons per week can be obtained. The cry of every catering officer and every dietitian is, "Oh, for more eggs and milk!"

Difficult as conditions may be, imagination can be exercised in preparing and serving food. At the famous hospital of St. Mary's, Paddington, now known as the penicillin hospital, I observed an evening meal being prepared for patients and staff. It began with hors d'oeuvre and consisted of a number of savoury and salad dishes, sliced cold meat, rolls and butter. The staff helped themselves to all the dishes, this method having been found psychologically good, and economical. A fruit course followed the meat—a slice of cantaloupe. Fresh fruit is served whenever possible; advantage is taken of the market to buy economically.

In the big kitchens of St. George's Hospital, which faces the gardens of Buckingham Palace at Hyde Park Corner, London, I saw the kitchen staff busy with chickens and baskets of mushrooms, preparing chicken *en casserole* for the nurses and patients

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Courtesy of the United Kingdom Information Office. The author is a former official of Britain's Ministry of Food.

next day. The next time the catering officer would be able to buy chickens economically, it would be the turn of the sisters and doctors to have this savoury dish. Seldom is there enough for everyone in the establishment on one occasion, so all good things are served in strict rotation.

At St. George's, ice cream is on the menu almost every day. Some days it is available to the staff and on others to patients; it is always given to patients with throat ailments. Occasionally it is served with chocolate sauce for extra nourishment or with black currant or other fruit puree to make up the necessary vitamin C intake for the day. Some hospitals make their own cakes for tea. St. George's Hospital, cramped for space, hands its baking permit for fat and sugar to a famous firm of caterers, who send back jam rolls, jam tarts and chocolate cakes. These are supplied to the staff for tea three times a week and one afternoon on the weekend.

In the same hospital, it is customary to give each staff member and patient his own weekly ration of butter, margarine, sugar and preserves. The catering officer believes that individuals, using them as they prefer (the fats on potatoes or on fish rather than on bread, and the sugar on fruit or puddings rather than in beverages), thus obtain the full intake of these valuable items of diet.

The final stage in catering has by no means been attained. Each hospital aims at still higher standards of diet. As yet, the profession of hospital dietitian or nutrition expert is in an infant stage in Britain, but since salaries for these posts are higher than formerly, young people are being attracted to them in greater numbers and will be welcomed by hospital committees.

If the standard of fare in some London hospitals is exceptionally high, it has been made possible by the advent of the catering officer whose function is to see that waste is eliminated, that commodities are purchased to the best advantage and on the best market, and that thought and care are given to the planning of meals.

Where Does Cancer Most Often Develop?

Deaths from cancer in Canada, 1947:

1.	Stomach	2,768
2.	Large bowel	2,120
3.	Breast	1,462
4.	Uterus	1,089
5.	Respiratory tract	1,137
6.	Male genital organs	900
7.	Rectum and anus	866
8.	Urinary tract	804
9.	Liver and biliary passages	774
10.	Mouth and throat	537
11.	Others, and non-specified	3,148
	Total all sites	15,605
	Male	8,045
	Female	7,560

Estimated population 12,558,000

—Canadian Cancer Society Newsletter.

X-Ray Unit Tours Rural Districts in Tasmania

In its first three years of operation a mobile x-ray unit, touring the island of Tasmania in conjunction with the State Public Health Department, has provided a precautionary check for about 40,000 people—factory and office workers, farmers and miners, school children and housewives. Operated by a team of three—chief technician, clerk, and woman attendant—and handling up to 150 people a day, the unit is on the road for the greater part of the year. It covers the State in about 18 months, making a stay at any place where there are 100 or more people settled within reasonable distance.

With the exception of the rotating anode tube, the unit was designed, manufactured and equipped in Australia. It has an over-all length of 31 feet and an internal width of approximately 8 feet. Although most of the films are developed in Hobart, a dark-room is incorporated in the unit. Pictures are read through a 35 mm. strip projector throwing a 10 by 8 in. enlargement. In addition, 14 by 17 in. x-ray pictures can be taken to check on doubtful cases revealed by 35 mm. shots.—* ***Office of the Australian High Commissioner.***

QUIET

HOSPITAL ZONE!"

SOUND

ABSORBING

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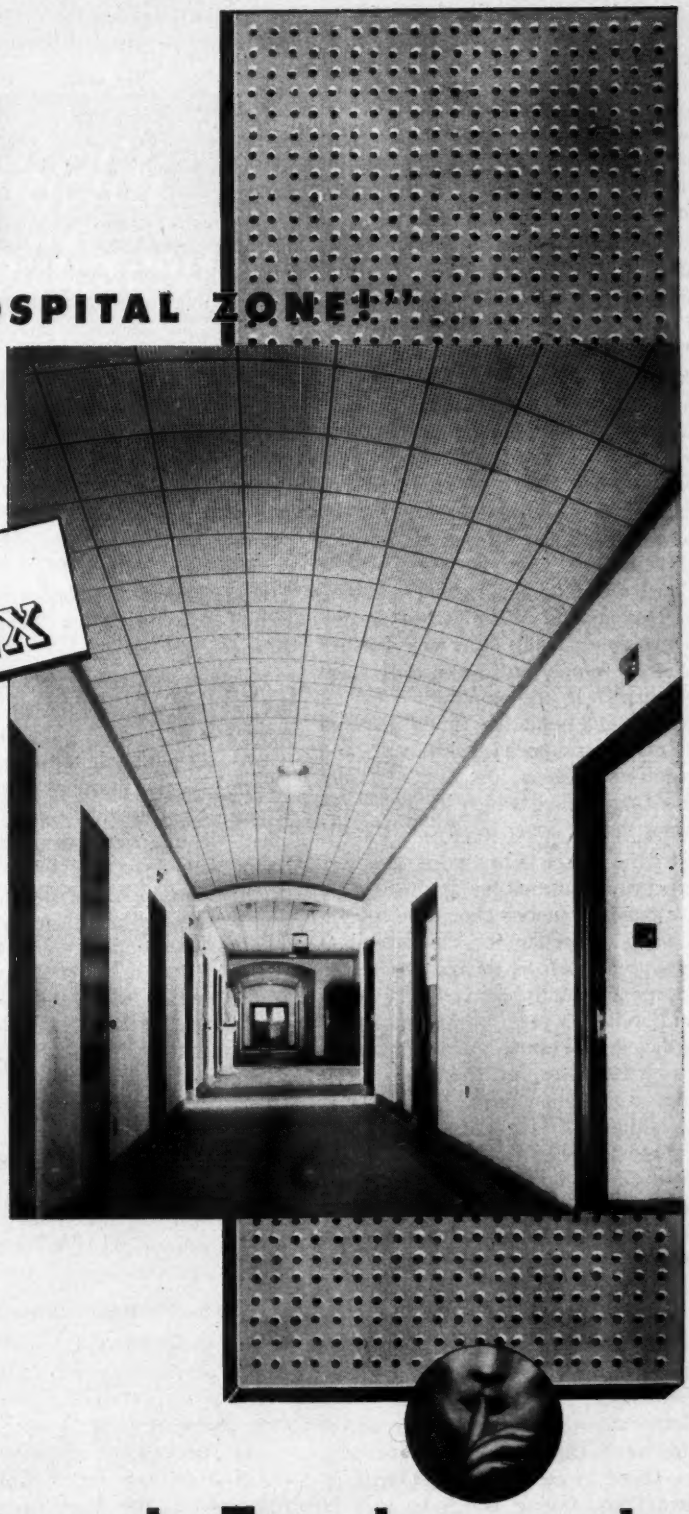

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Hospital Collections

(Concluded from page 32)

After judgment has been obtained by default, immediate court action can be taken; if by trial, 15 days must elapse and then, if the account has not been settled, the following courses are open.

If the defendant is employed or has a bank account, an attaching order or garnishee should be issued. There is little difference between these two. In an attaching order the work of issuing it, having it signed by the judge, registering and serving it, is done by the hospital and the fee is only 50 cents. If the hospital wishes the court to serve it, there is an additional charge of 50 cents. In a garnishee, the issuing, et cetera, is done by the Division Court staff and the regular schedule of fees applies. When issued against wages an attaching order or garnishee is effective only on the ensuing wage payment. If the employer does not deduct and remit the funds involved he may be subpoenaed into court and required to show just cause for not so doing, failing which the court can order the employer to pay.

If the debtor is in a position where his income cannot be garnisheed, a judgment summons should be sought. This is an order for the defendant to appear before the court for an examination into his assets, liabilities, and ability to pay. If his means are sufficient, the court will order him to pay. However, if the court feels that at the moment he is unable to pay, the case is adjourned *sine die*, or indefinitely. The only time the case should be brought to trial again is when evidence is available that the debtor's financial position may have changed sufficiently to allow him to commence payments.

Should the defendant fail to adhere to the court order issued under the Judgment Summons, a "Shew Cause Summons" should be issued. The defendant must again appear before the court and show just cause why he failed to carry out the court's instructions, failing which he may be committed to jail for contempt of court. Should the defendant fail to appear for either a Judgment Summons or Shew Cause Summons, he is running the risk of confinement for contempt of court. The above procedure (in successful actions the costs are assessed against the debtor) usually brings payment of the account.

General

Collection campaigns or drives are much more effective at certain times of the year and month. For instance, in a locality where there are many governmental employees who are paid monthly, it may be practical to have the accounts prepared daily but held for mailing until just prior to the end of the month. In industrial centres, pay days are usually weekly or semi-monthly and accounts should be mailed out to arrive at the home just before pay day. Various seasons of the year also affect collections. In the late fall, fuel and winter clothing must be purchased; Christmas and summer holidays always make a dent in the family budget. The best period for a sustained and concentrated collection drive is from February to June.

Hospital collection personnel cannot operate efficiently when there is outside interference. This is particularly true in smaller communities where, if the hospital decides on strong action against a certain delinquent debtor, some member of the board will object for fear of losing personal business and local prestige, or of stepping on an acquaintance's toes. This has been true in too many cases. No hospital collection policy or staff can function properly without the wholehearted and unanimous support of the hospital board and the administrator.

Newer Dietary Equipment

(Concluded from page 46)

develop a great deal more, and has a very definite place in future food production.

Methodist Hospital, Brooklyn

This is a 540-bed hospital which has a completely new kitchen with decentralized service.

Features of interest were:

(a) "SteamChef" Steamers—2 units of 3 sections each. The shelves come out as the doors open;

(b) Groen Steam Jacketted Kettles with solid base: 1—40 gallon tilting; 3—60 gallon solid; 2—40 gallon solid;

(c) Bastiam-Blessing Ice Cream Machine. They use 40 gallons of ice cream per week and buy the mix which costs 50.5 cents per quart. They use 110 per cent overrun and claim a considerable saving as commercial ice cream costs 49 cents per quart. Then, too, it is possible to have more variety in the ice cream served. One feature which I like was the warming cabinet built into one end of the "ripening" cabinet. Ice cream to be used that day was "warmed" for three hours which made it the proper consistency to serve.

Other Equipment

Equipment demonstrated at the Convention included most types of food trucks, sinks, stoves, and food preparation units.

I was interested in a discussion about rotary gas ovens. Mr. Grogan of Blodgett's says this type of oven is good only for straight line production, and does not allow for flexibility of baked goods. He states they are difficult to operate and must be shut down two days at a time to be cleaned. At the Massachusetts General Hospital they have used rotary gas ovens for several years, and do all the baking for the hospital including 120 loaves of bread a day. They say they need cleaning only every six months and this operation takes 12 to 18 hours.

Potato peelers are now made with a solid base of stainless steel and a new feature is having the water come in from the top. Both Hobart and Blakeslee Companies have streamlined the shafts on their mixers.

Several types of pre-rinse units were used. The Hobart Company use surplus water from the wash tank to flush dishes.

New types of Lowerators for every kind of dish are in general use.

Blickman Company are now building cabinet and counter doors of box construction, insulating them for noise. This type of door is naturally much easier to clean but the cost will be considerably higher.

The "Qualheim" Electro food cutter is a compact machine which does a very large volume of work, and does it very efficiently. It is easy to clean and to operate. Cost of the machine on display was $625!

All manufacturers would seem to be keenly interested in producing equipment which will operate efficiently and be easy to clean and maintain.

Hospital Needs

(Concluded from page 28)

lic relations factor in not entering more actively into the ambulance service field. The type of service to be rendered would, in the case of the hospital, depend largely on the size and location of the community. In cities, the hospitals might set up a joint ambulance service, or they might co-operate with local authorities or with service clubs.

For rural hospitals, government assistance might be necessary and, for projects such as Saskatchewan's flying ambulance service, outright government support would be needed. The important thing is that the hospitals should give leadership and direction, aid in the training of ambulance staffs and, where necessary, provide the professional personnel required to accompany the ambulance.

Co-ordination with Special Hospitals

The foregoing has dealt chiefly with the co-ordination of general hospitals, large and small, to ensure the greatest possible measure of service to the community. There remains, however, another form of co-ordination, namely, that of the various types of hospitals. There is a marked similarity between developments in medical practice and in the hospital field. There has been a trend from almost universal general practice to specialization in medicine and, of late, the pooling of skills in the form of joint practices or clinics. Similarly, in the days of limited methods of treatment, hospitals were prepared to accept almost any type of case but, since the early years of this century, hospitals themselves have become largely specialized, with individual institutions for mental diseases, tuberculosis, paediatrics, et cetera.

A number of outstanding authorities now contend that these various hospital groups should be returned to the fold of the general hospital and that a general hospital should be a *general* hospital in fact, as well as in name, with wards or sections for each type of disease. Such a proposal has obvious merit from the standpoint of utilization of skilled services and costly diagnostic equipment as there are few, if any, staff specialties or diagnostic facilities of the general hospital that are not required by the special hospital.

On the other hand, such a proposal is feasible only for large hospitals in densely populated areas and could not be laid down as a standard of planning for the average hospital or the average community. It rests with hospitals to develop an organization that will fully meet community needs in respect to these specialized fields. The needs may be summarized as follows:

1. Adequate diagnostic service;
2. Facilities for immediate emergency hospitalization where indicated;
3. Ample hospital accommodation of the specialized type required by the patient;
4. An efficient follow-up system for patients who have recovered sufficiently to return to their homes.

The small hospital of the future must, and will, play an important part in this chain of specialized needs. Its diagnostic facilities, frequently subsidized by government funds, and the services of its consulting specialists, will ensure prompt and accurate diagnosis and treatment. It will have wards designed to provide efficient care for emergency cases, for those with psychopathic conditions or communicable disease, and other urgent special cases coming to its doors. Although the small hospital may not be able to treat the patient, except for the initial or emergency period, it can, by affiliation with special hospitals in its area, make certain that he is transferred to a competent treatment centre without delay. Again, by its records of previous hospitalization and its intimate knowledge of family histories in the community, the rural hospital will be in a position to render helpful guidance to the staff of the specialized hospital. It will, by the use of its diagnostic and treatment services, be able to aid local health authorities to establish and conduct efficient follow-up services.

Finally, if it is to serve its community effectively in this field, the smaller hospital should make arrangements for the key personnel of its medical and nursing staffs to take regular post-graduate or refresher courses at affiliated special hospitals. The value of such training has been amply demonstrated in the education of student nurses and interns. Its extension to the key staffs of all general hospitals, and particularly to smaller hospitals, would speedily be reflected in the health and well-being of the community.

Conclusion

In review, it may be emphasized that the hospital needs of the community will not be met until its residents have available, either within the boundaries of the community or by means of an efficient transportation system, every accepted diagnostic and treatment facility, co-ordinated in such a way that the scientific care of the patient commences immediately upon admission to hospital and continues without interruption as long as hospitalization is required.

To accomplish this will necessitate co-ordination of hospital services by long-term planning and co-operation, and adequate financial resources based on an efficient health insurance program on either a voluntary or a state basis.

Some of the more important hospital needs of the community have been outlined above, but the greatest community need is the continuation of the voluntary hospital. In every part of Canada there is a steadily increasing demand for social security with medical and hospital services largely under the spotlight. The various political parties, keenly alive to the will of the people, are clamouring for opportunities to be the first to sponsor popular health measures. It is almost inevitable that vigorous representations will be made to the government to assume control of all hospital facilities, as has been done in certain other parts of the British Empire. The voluntary hospital must shortly be prepared to rest before the bar of public opinion the case for its continued existence. Hospitals themselves will have to demonstrate to the public that a properly co-ordinated system of voluntary, municipal and government hospitals can, in a land of free enterprise, render to the community a type of service which no form of bureaucratic control can hope to equal.

The road ahead will not be an easy one, but if we face it with confidence and vigour and give unstintingly of ourselves in the development of a better hospital service, we shall eventually see the pattern of the community controlled hospital firmly woven into the fabric of a nation-wide health service.

Long-Term Patients

(Concluded from page 34)

and shows equal variation for the same patient at different times. The patient may be up and about today, and down tomorrow. He may be bedridden for weeks, then ambulant again, only to go down again later. This tendency of patients to follow an uneven course is one of the factors which makes it impossible to differentiate sharply between groups of patients, and to separate various groups for long-continued care in markedly different types of institutions. The types of *care* needed can be distinguished and separate facilities can be established to provide different types of *services*. I know of no way yet developed, however, to differentiate groups of patients and attempt to meet their needs in separate institutions without confusion and duplication in services.

In general, patients with chronic illnesses need two broad types of care:

(a) Diagnostic and treatment services requiring specialized equipment and personnel;

(b) Personal care and routine nursing service under generalized medical supervision which must be continued for long periods of time but requires no specialized equipment or personnel which could not be provided ordinarily in the patient's own home.

The diagnostic and treatment services necessary for the care of chronically ill patients are, in general, the same as those required in the care of any other sick people. It is an expensive and unnecessary procedure to duplicate facilities and specialized staff of this kind by operating one set for the so-called "acute" patients and another for the "chronics". This is one of the reasons why Dr. Bluestone, and others with experience in this field, urge so strongly that we stop thinking in terms of separation between the acutely ill and the chronically ill, and begin to recognize the general hospital as the centre where specialized services should be provided for patients of all types without arbitrary distinctions.

It is important, however, to recognize that this need for specialized facilities and services is something rather different from the patient's everyday need for a home where he can live and receive personal care, general medical supervision, and whatever nursing service he may require. Like all other human beings, chronically ill persons need a home, or a substitute for it, as well as a hospital to which they can go for specialized study or treatment.

These "substitute homes" may take the form of privately-operated small nursing homes, of county infirmaries, of "homes for incurables", or of infirmary sections in homes for the aged. They may be operated as adjuncts to hospitals or may stand as independent institutions in the community. The important point is that their character be clearly understood as "homes", and that they represent the patients' own homes in their relationship to hospitals. The home and the hospital each has its own function to perform. Both are essential and they should not be confused.

4. *Human Elements Involved in Planning Substitute Homes.*

From a purely practical point of view there is no reason, except the humane one, for giving care or protection of any kind to permanently disabled patients. They probably will never again be productive members of the family unit or of society. They cannot be expected in the future to "repay the investment" which is made in their care. The sole reason for providing care is, therefore, to help make their final weeks, months, or years of life more comfortable and easier to bear. It is unfortunate that too often we have lost sight of this fact. In our zeal to give the patient what we believed was best (or perhaps only what was easier for us to provide) we have overlooked the importance of his feelings and his personal desires. Physical requirements too often have been met with a high degree of efficiency, but at the sacrifice of less tangible things which, to the patient, seemed far more important. It is not always easy to evaluate the importance of these intangibles and to weigh them accurately against the very tangible need for physical care. It is highly important, however, that this be done. There is nothing humane in letting our anxiety for a patient's physical welfare lead us into forcibly tearing an individual loose from all that he holds dear, and thus condemning him to live out the last months or years of his life in sterile emptiness, misery and loneliness.

It would be helpful, I think, if all of us involved in planning and developing facilities for care of this kind would ask ourselves at least once a day, "Is this the care I shall want when my turn comes? Is this what I want for my mother, my father, or my sister?" If we cannot honestly answer "yes" to these questions, it is time to re-examine every plan we have made. This need for care is not something which happens only to others. The chances are very great that it will come to you and to me. Even though we might be so fortunate as to be spared personal experience, we still must not forget that those in need of care today require the same consideration that we ourselves would want. The heartbreak and human misery depicted in the stories and movies of twenty-five or fifty years ago when people went "over the hill to the Poorhouse" is not so far removed from present every-day life as we should like to believe.

Let us work steadily toward efficient use of hospital beds; toward intelligent community planning; and toward the development of the best possible facilities for physical care of chronically sick and helpless people. But in doing so, let us not forget that we are dealing with human beings who are facing personal tragedies, helplessness, and the ending of their lives. Let us season our planning with human understanding, and let us not forget the spiritual and emotional factors which sometimes seem to the patient of far greater importance than his physical need alone.

Dr. Frank Bradley Institutes Chairman

Frank R. Bradley, M.D., Director of Barnes Hospital, St. Louis, Mo., is chairman of this year's A.C.H.A. Central Committee on Institutes which will meet April 15 in Drake Hotel, Chicago. The Committee will consider the educational programs being arranged for hospital administrators at geographically strategic points.

An evaluation of past institutes and a report of progress on those pending will be before this Committee.

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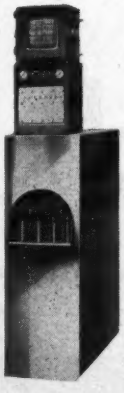

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Book Reviews

MAYO CLINIC DIET MANUAL. By the Committee on Dietetics of the Mayo Clinic. Pp. 329. Price $4.40. Published by W. B. Saunders, Philadelphia. Canadian agents, McAinsh and Co. Ltd., Toronto. 1949.

Dietary procedures, prepared originally for limited use in teaching and planning patients' diets, have been recently assembled and published in book form by the Mayo Clinic. This valuable book is being made available to persons with training in medicine and dietetics and is not intended for direct distribution to patients. While the diets represent the convergent trend, but not unanimity of opinion of the clinic physicians, they are recommended as standard procedures which may be modified according to the needs of individual patients.

Each diet in this comprehensive manual has been previously tested and subjected to a period of practice. Included in the manual are standard hospital diets (general, light, soft, and liquid) and tube feedings, dietary programs following general operations, and specific programs for gastric and duodenal ulcers, diseases of the gallbladder and the liver, for allergy, cardiorenal vascular disease, diabetes, anaemia, and pregnancy.

Children's diets are also described, and these include general hospital diets and various dietary programs for specific conditions. The Appendix offers a variety of informative charts and detailed reference tables: listings of foods high in vitamins, minerals, carbohydrates, calcium, et cetera; average composition of 100 Gm. of foods; approximate composition and recipes for certain foods; height-weight-age tables for men, women, and children; and a food nomogram.

* * * *

ANESTHESIA PRINCIPLES AND PRACTICE. By Alice M. Hunt, R.N., Associate Professor of Anesthesia Emeritus, Yale School of Medicine, New Haven, Conn. Pp. 148. Illustrated. Price $2.90. Published by G. P. Putnam's Sons, New York, 1949. Canadian agents, McAinsh and Co., Limited, Toronto.

One of the first of her profession to enter the specialized field of anesthesiology, Miss Hunt in this book reflects throughout her broad knowledge of the subject. The volume is an outgrowth of the author's many years of experience in responsible positions, and in teaching, and covers very thoroughly the use of various anesthetics and analgesics.

Stressing the importance of correct procedures in the administration of anesthesia, Miss Hunt also explains the reaction of patients. As well as chapters on the different types of anesthesia, there are chapters devoted to premedication, general immediate pre-operative and post-operative care of the patient, obstetrical anesthesia, and oxygen therapy.

The material is compiled chiefly as a ready reference for nurses engaged as anesthetists and as a concise text for students in this field. There are no nurse anesthetists in Canada but the book would make valuable reading for operating room nurses.

Be not careless in deeds, nor confused in words, nor rambling in thought.—*Marcus Aurelius.*

How to have one less administrative headache

'Oxygen Therapy-wise' hospital administrators know the advantages of having an oxygen therapy department. Here are some of the services to users of DOMINION Oxygen (B.P.) that can help you to organize and operate a smooth running oxygen therapy department in your hospital; just write or phone the nearest Dominion Oxygen office.

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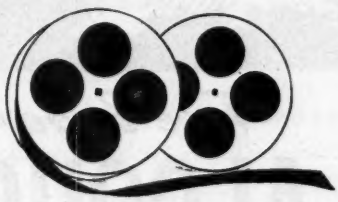

MOTION PICTURES: "Oxygen Therapy Procedures"; "Physiology of Anoxia"; "Oxygen Therapy in Heart Disease."

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Ethical Code Featured by New Society of Pathologists

Pathologists in Alberta have recently organized the Alberta Society of Pathologists. This Society is closely allied to the College of Physicians and Surgeons of that province and is subject to the rules and regulations of the College. The Society is also affiliated with the Canadian Association of Pathologists. The secretary is Dr. John D. Duffin, Colonel Belcher Hospital, Calgary.

An interesting code of ethics has been adopted by the Society. Members are required to follow this code, agreeing:

(1) That the practice of pathology shall be so conducted that the greatest possible benefits will accrue to the sick and injured.

(2) That the fullest measure of co-operation with other members of the Society is a necessary and desirable concomitant of exemplary practice.

(3) That no member may solicit, may permit others to solicit on his behalf, nor may he accept, a position which is occupied by another pathologist, without prior consultation with that pathologist.

(4) That no member may issue a report on preparations or material from the laboratory of another pathologist, without having been requested to do so by that pathologist.

(5) That no member may, directly or by means of subterfuge, divide fees from laboratory services with referring physicians.

(6) That the members of the Society shall conform with the current regulations establishing minimum fees for laboratory services as published by the College of Physicians and Surgeons of Alberta.

(7) That laboratory or other reports are confidential documents, not to be issued to patients without the consent of the attending physician, if any.

(8) That members may not participate in any arrangement whereby an individual, not regularly licensed to practise medicine, is encouraged to operate a clinical or pathological laboratory.

Saskatchewan Government Sponsors Institutes in Hospital Accounting

During a period of four weeks, 125 hospital accountants from all parts of Saskatchewan recently attended four training institutes conducted under the auspices of the Health Services Planning Commission.

Each training course lasted four full days, with two institutes held at Saskatoon and two at Regina. The highlight of each course was the practice period for hospital accounting problems. Each candidate was handed a set of miscellaneous documents, including admission-discharge forms, charge memoranda, duplicate receipts, duplicate deposit slips, cheque stubs, paid cheques, payroll forms, and invoices. From them, the candidate produced a report showing the revenue and expenditure for the hospital.

It is hoped that these courses, made possible by a substantial grant from the Dominion government, will be the beginning of a series of training projects designed to assist hospital staffs with their many problems.

A.C.H.A. Educational Fund Receiving Considerable Support

In the fund raising campaign for educational purposes now being carried out by the American College of Hospital Administrators, the Ontario Hospital Association leads all participating associations with its subscription of $1,000, according to an announcement by Dr. Wilmar Allen, chairman of the campaign. In transmitting the contribution from the O.H.A., Dr. Fred W. Routley, secretary-treasurer, stated:

"It was unanimously resolved that, in view of the co-operation which the College has already so generously extended to the hospitals of the Province of Ontario in connection with the institute held in London last spring and the very broad educational program which you are planning, our association would like to make a contribution toward the service which you are rendering."

The College's objective is a minimum of $425,000 for a five-year educational program, the purpose of which is to raise the general level of hospital administration (see *Canadian Hospital*, March, 1949, page 26).

Trustees, hospitals, associations, and corporations, are giving generously to the fund. Among early subscriptions from trustees was the amount of $2,570 from the board of St. Vincent's Hospital, New York City, $2,000 from the trustees of Elizabeth Steele Magee Hospital, Pittsburgh, and $1,500 from the board of Hartford Hospital, Hartford, Conn.

Some of the early corporation subscriptions were the following: American Hospital Supply Corporation, Evanston, Ill., $25,000; Simmons Company, New York City, $15,000; Will, Folsom, and Smith, Inc., New York, $11,000; A. S. Aloe Company Charitable Trust, St. Louis, Mo., $10,000; Huntingdon Laboratories, Inc., Huntingdon, Ind., $5,000.

Individual members and hospitals are supporting the campaign in amounts from $10 to $1,100. The entire College membership of 1,600 administrators are assisting in their various communities and the Regents of the 15 geographical areas into which the membership is divided have been named chairmen of regional committees to aid the campaign.

R. Fraser Armstrong, superintendent of the Kingston General Hospital, is chairman of Region No. 14, which includes all provinces in eastern Canada. Alexander Esson, superintendent of Saskatoon City Hospital, is chairman of Region No. 15, which covers the western provinces.

—Dean Conley.

The Inadequacies of Rural Medical Services

With the inadequacies of medical personnel and facilities in rural areas, it is clear that rural people must receive a volume of medical services far below their true needs. The fact is that for practically every category of service, with the exception perhaps of the dubious benefits of midwives and patent medicines, the rural population receives services smaller in quantity and lower in quality than the urban, and far less adequate than would be warranted by the burden of illness and impairment that it bears.

—From "Rural Health and Medical Care" by F. D. Mott and M. I. Roemer.

Basis of Medical Economics is Political Philosophy

Eventually every problem in medical and hospital administration resolves itself into one problem; namely, "Does one advocate individual enterprise or does one advocate totalitarianism, in one of its many forms, Fascism, Communism, or Paternalism (either benevolent or autocratic)?" Eventually every problem of medical and hospital economics resolves itself into one of political philosophy. Because of their long experience those representing the professions at the council tables of the great are the older practitioners whose practising days are about over. The undergraduates, the interns, and the young practitioners are the ones who should be asking the question: "What is the future of medical practice and hospitalization?"

Study groups should be formed, policies enunciated and the education of the public should be undertaken by the younger groups. For the past three or four decades, a great deal of counterfeit currency in the form of impressionistic nonsense has been accepted by the public as the good coin of factual information. As a result, ill-conceived and poorly-operated schemes for medical and hospital care have sprung up throughout the length and breadth of the land. These plans are those of opportunists. They have been inaugurated without any apparent thought for their effect on the very soul of the people. Even such a valuable commodity as health can be bought at too high a price, particularly if that price involves the loss of personal liberty and individualism.—*Dr. A. C. McGugan, University of Alberta Hospital, Edmonton.*

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12 Red Cross Units Opened This Year

Since the first of this year, the Red Cross has opened 12 new outpost hospitals and nursing stations in Canada. Some 70,000 patients are served yearly by 75 of these outposts and nursing stations. During 1948, Red Cross nurses assisted at the birth of 3,600 babies, inspected more than 20,000 school children, and provided approximately 121,000 days of hospital care.

A.H.A. Conference

(Concluded from page 38)

association is the director of the plan. Where this control does not exist there are nearly always serious differences of opinion between hospitals and the plan, and seldom is the full cost of hospital care paid by the plan.

It was generally agreed that there is no good reason why hospital associations cannot operate successful pre-payment plans which would make it possible for individuals to provide against the full cost of hospital care. Success would depend, however, upon the provision of full coverage and not just indemnity payments. It was encouraging to note that the Blue Cross movement is becoming more and more popular, that it has the approval alike of labour leaders and of governments, and that apparently President Truman intends no immediate interference with the voluntary character of hospitals or the organization of Blue Cross plans, regardless of the possible introduction of state medicine.

Dr. W. W. White Serves on Hospital Board for 25 Years

Dr. Walter W. White, associated with the Saint John General Hospital, Saint John, N.B., since 1890 when he became a member of the visiting medical staff, has been named honorary president of the board of that hospital. For the past 25 years he has served continuously on the board of trustees and has acted as president since 1938. He is succeeded by Mr. J. F. H. Teed, K.C.

POSITION WANTED
ASSISTANT ADMINISTRATOR

Age 30, 6½ years' hospital experience including accountant, business management, purchasing, personnel relations, credits and collections. To sum up—general administrative work, covering both the business and professional phases of hospital administration. 6 years' public accounting and auditing experience. Box 163M, The Canadian Hospital, 57 Bloor St. W., Toronto 5, Ont.

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Two hundred bed modern general hospital, fully approved with Training School for Nurses. Full maintenance and suite. State age, experience, qualifications, salary expected. Thirty days annual vacation. Royal Inland Hospital, Kamloops, B.C.

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1 Night Supervisor May 1st. 1 Asst. Night Supervisor May 1st. 1 Supervisor for Surgical Ward May 1st. General Duty Nurses—at once. Apply stating qualifications to Miss O. Waterman, Reg.N., Superintendent of Nurses, McKellar General Hospital, Fort William, Ontario.

POSITION WANTED

Administrator — female, lay. Good qualifications and experience, wishes to locate in 50-150 bed hospital in Eastern Ontario. Can furnish the highest credentials. Box 765L, The Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

POSITION OPEN FOR AN X-RAY TECHNICIAN

Preferably a Graduate nurse who could assume part time nursing duties. Apply Superintendent, Carleton County L. P. Fisher Memorial Hospital, Woodstock, New Brunswick.

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Progress in Cardiac Studies Resulting from Research Funds

Financial support for heart disease research reached a new high during 1948, according to a summary issued by the Life Insurance Medical Research Fund and, as 1949 begins, more trained scientists are at work in the field and more research is in progress than probably ever before.

Although heart disease kills more men and women than any other disease, scientists had little financial support for their research in the field until three years ago. In 1945, the life insurance companies of the United States and Canada, recognizing the lack of research, set up the first private agency devoted entirely to this study. Since that time the life insurance companies have contributed approximately $600,000 annually to hospitals, universities, and individual students. The total so far amounts to $1,900,000.

In 1949 heart disease research will continue to centre around the three most serious conditions—rheumatic fever, arteriosclerosis, and hypertension.

One of the significant developments of 1948 was the increased use of radio-active isotopes, which scientists used to "flag" food elements, drugs, and other substances introduced into the body. Out of this new technique have come studies of the role of cholesterol in arteriosclerosis, the changes which take place with age in the heart muscle, the action of such drugs as digitalis, and the disturbances of body fluids, such as those occurring in oedema.

The relationship between arteriosclerosis and cholesterol received a great deal of investigation during 1948 and evidence is accumulating that it does play an important role in the development of hardening of the arteries. Cholesterol is included in such foods as eggs and milk but it is also readily manufactured in the body itself. It is uncertain whether its presence in food is responsible for arteriosclerosis.

During 1948, particularly at Duke University, research was continued in the effect of the "rice diet" in the treatment of high blood pressure. Opinion still differs as to the value of this treatment but the results are such as to require further study; at Duke, two-thirds of the patients treated are reported to show improvement, often of marked degree, although some workers at other institutions have failed to obtain success. The diet is notable in its almost complete lack of salt.

The nature of heart disease discourages any hope of some new and startling cure or method of prevention in the next few years. But medical knowledge of the disease and of the function of the cardio-vascular system is increasing at a dramatic rate, laying the same kind of foundation in the field of heart disease as preceded the discovery of insulin for diabetes and the discovery of the sulfa drugs, penicillin, and streptomycin for infectious diseases.

Those who cannot remember the past are condemned to repeat it.—*George Santayana.*

Hospital Pharmacy

(Concluded from page 42)

hospital. Our main bugbear is the preparation of ointments and lotions for specific skin conditions, as they entail considerable work and an immense amount of time, and tax one's ingenuity no end.

In hospital dispensing the apprentice should pick up a good training in prescription reading as there are about as many prescriptions dispensed in hospital as there would be in a retail store and there is certainly no difference in the writing. The interns, on the other hand, are eager for the knowledge necessary to write prescriptions and they go to the hospital pharmacy for help. Their greatest difficulty seems to be in getting to know the strengths of the various tablets, solutions, or medicines, which they are called upon to prescribe. We are only too glad to help them out in this matter.

We have found it rather difficult to teach the *materia medica* that is behind our medicines, such as tablets, injections, and parenteral solutions, due to the multiplicity of the products. So many trade names are confusing and no one seems to be exactly sure just how similar, or dissimilar, these products are. As a consequence we carry two or three of similar composition, under different trade names.

In his last year, our apprentice made astounding amounts of pharmaceutical preparations. He prepared, among other quantities of drugs, 27,800 grams of penicillin cream; 120 gallons of emulsions; over 37 gallons of mixtures; 69 pounds of ointments; over 245 gallons of solutions, as well as varying amounts of tinctures, syrups, suppositories, spirits, elixirs, corn solvent, and capsules.

It was the author's pleasure to talk to the senior medical class last year on the subject of "what a pharmacist expects of the physician in his prescription writing". At the same time a good briefing on the Narcotic Act was given, in so far as the writing of narcotic prescriptions was concerned. Several members of the class expressed their appreciation and even called at the pharmacy for further talks.

One can readily see that the influence of the hospital pharmacy extends far beyond the hospital itself, particularly in a teaching hospital connected with a university. Any apprentice having been connected with such a department for two or three years should have groundwork that is rather unique. The practice of hospital pharmacy has certain specific advantages; e.g., regular hours, no night work (except for emergencies), a couple of hours' work every other Sunday, three weeks' holidays with pay, and a pension plan.

Great Boost in C.S.L.T. Membership

In the ten-year period between 1937 and 1947, the membership of the Canadian Society of Laboratory Technologists increased in numbers from 190 members in 1937 to 1057 in 1947. The Society plans to have, in the not too distant future, a field representative who will travel the length and breadth of Canada, helping to bring about an exchange of ideas and knowledge which is so necessary for the advancement of medical technology.

With Hospitals in Britain

(Concluded from page 50)

tain the extent to which it is productively valuable. The sort of thing which may be given as an example is the hospital record department. It must be admitted that it has lagged behind in this country and some hospital authorities have suddenly awoke to the fact. The scarcity of record officers has led to a scale of salaries out of all proportion to those of colleagues working alongside them, with staffs of a quite remarkable size. Again, the teaching hospitals have been foremost in this field to such an extent that it has almost become a craze, although their records are by no means the most useful from a national point of view, nor even for the teaching of medical students.

The irony of the situation is that the teaching hospitals having clamoured for independence are now going to the Minister to ask him to tell them what to do. There is one obvious answer which they ought to have provided years ago and that is the establishment of a real system of budgetary control. Particulars of action taken may need to form the subject of another letter. When the health services are costing every income tax-payer 17½d (say forty cents) on the pound, the subject is likely to remain a live one for all who realize that fact.

Notes on Federal Grants

(Concluded from page 44)

League hopes to increase its surveys to reach 300,000 persons.

Assistance has been granted to the Notre Dame Hospital, Montreal, in the purchase of x-ray equipment which will be used to examine all persons admitted to hospital or attending the out-patient department—about 25,000 persons a year.

* * * *

Vital Statistics

Use of federal funds has been approved for the appointment of two inspectors of vital statistics for Saskatchewan. They will be responsible for examining copies of registrations of births, marriages, and deaths, in the offices of division registrars and assisting in the development of a speedier reporting service.

Hospital Liable for Patients' Property

The following extract from an English publication, concerning hospital liability for patients' property, may be of interest to our readers.

"The defendant was under a duty to maintain a hospital and admit patients. The defendant took possession of the plaintiff's handbag containing diamond jewellery when the plaintiff was admitted to the hospital. The contents of the handbag were noted in the defendant's ledger kept for that purpose and were stored with hundreds of other articles in envelopes. The Court held the defendant liable to the plaintiff when the contents of the handbag were missing; and the Court stated that the defendant was not entitled to assume that a patient's property was of little value. In appraising the missing property consideration was given to the prevailing purchase price and luxury taxes. Martin vs. London Council (1947) I A.E.R. 783."

Flavoured Milk Drink

Recently there has been much discussion concerning the nutritive value of chocolate flavoured dairy drink as a food for children. Some have gone so far as to say that it is detrimental to the health of children. Their main arguments upholding this view are that the skimmed milk from which it is prepared is of doubtful quality, that the quantity of the tannic and oxalic acid in the cocoa lessens the calcium retention in the human body, that it impairs children's appetites, and that the theobromine in cocoa is a stimulant and harmful for children.

The term "milk" under the laws of most provinces refers to the unchanged natural product with at least 3.25 per cent butterfat. Skimmed milk refers to the same quality of product except for the removal of some or of all the butterfat. Skimmed milk still contains most of the food value of whole milk. The calcium, protein and vitamin content (except vitamin A) are the same, but the caloric content or food energy is less, due to removal of fat. In flavoured skimmed milk drinks the addition of sugar brings the caloric value up slightly higher than whole milk. Because the process of making flavoured milk drinks takes longer and since it has the added ingredients, the bacterial count may be slightly higher, but there are legal limits for safety and such products are under constant inspection.

Cocoa contains tannic and oxalic acid. When a large amount of cocoa is present the calcium retention in the body is affected. This rarely happens since cocoa is chiefly used as a flavouring. The amount used in making chocolate flavoured dairy drinks, which is usually from 1 to 2 per cent, has no detectable injurious effect on the metabolism of calcium in humans. The theobromine present in quantities ordinarily consumed would not have any stimulating effect.

The presence of a considerable amount of extra sugar in flavoured milk or skimmed milk drinks is undesirable for its bad effects in promoting dental decay. The sugar content also seems to decrease the appetite of children especially those who are not robust eaters. However, this can also happen with ordinary milk or any other food if drunk or eaten too soon before the next meal.

The use of flavoured milk drinks may cause children to refuse any other kind of milk. It has led children to demand at home that all their milk be so flavoured. Since flavoured milk is usually more expensive than ordinary milk many parents could not afford to buy all their milk in this form. The ultimate effect of providing chocolate dairy drinks at school can thus be a net decrease in the amount of milk taken by a child unless steps are taken to compensate. Such steps include feeding milk in pudding and sauces and are easy enough when parents realize what is happening.

The conclusion seems to be that it is better to have milk in this form than no milk at all because the skimmed milk from which it is usually made contains most of the nutritional value of the whole milk.—*Canadian Nutrition Notes, D.N.H. & W.*

Every tiny step forward in the world was formerly made at the cost of mental and physical torture.—*Nietzsche.*

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Second Empire Tuberculosis Conference

The National Association for the Prevention of Tuberculosis has announced that details are available concerning the second Commonwealth and Empire Health and Tuberculosis Conference. The Conference will be held in the Central Hall, London, Eng., July 5—8. Further information may be obtained from the NAPT, Tavistock House North, Tavistock Square, London, W.C.1.

Important Medical Conferences To be Held in Saskatoon

Two important medical conferences are to be held in Saskatoon in June. The annual meeting of the Canadian Medical Association will take place in that city during the week of June 13. As in previous years, a varied program of timely medical subjects will be considered during the week. At this meeting, Dr. J. F. C. Anderson of Saskatoon will succeed Dr. William Magner as President of the Association.

Of unusual interest, during the preceding week, will be the first meeting of the British Commonwealth Medical Conference. This will take place in the same city on June 7, 8, and 9. It is anticipated that delegates will be present from Australia, Ceylon, India, New Zealand, Pakistan, South Africa, Great Britain, and Canada. According to present plans one day of this Conference will feature a review of medical care in Canada, including the provision of hospital facilities.

The Auxiliaries

(Concluded from page 48)

Bunny sales, raffles, rummage sales, and fashion shows, have made successful the numerous projects of the auxiliary.

* * * *

Renfrew, Ont., Auxiliary Reports Much Activity

The Ladies' Aid of the Renfrew General Hospital spent an active year in 1948. In addition to purchasing innumerable items for the hospital and the nurses' residence, they completely refurnished the superintendent's quarters and renovated the Soldiers' Memorial Ward. Taxi service is provided for the student nurses that they may attend Sunday services, and theatre tickets are given to them periodically.

* * * *

Sudbury Auxiliary Works Toward New Hospital

The Women's Auxiliary to the Sudbury District Hospital, which is now under construction, is rendering several important services to the community. It makes available for renting or loaning an oxygen tent; this can be used in the home under doctor's orders. From its "Memorial Fund", memorial cards are given or sent out upon request to bereaved persons. An important money raising event of the year is the annual "Flower Tag Day", using flowers made by hand by auxiliary members.

You can't ignore the importance of a good digestion. The joy of life . . . . depends on a sound stomach, whereas a bad digestion inclines one to skepticism, incredulity, breeds black fancies, and thoughts of death.
—*Joseph Conrad.*

Short Form Report

The completion of insurance forms of hospitalized patients has been a growing problem during the past few years. Unless a definite plan is worked out, record departments are likely to be besieged by patients and insurance companies.

At Columbia Hospital, Milwaukee, a careful study was made of the time and effort spent in completing insurance reports for a two-month period. After accurate recording, the final statistics showed that the amount of time spent in filling in these blanks varied from about one minute to more than 45 minutes. As a result, rules were drawn up by a committee to regulate the release of information from the record.

1. The written authorization of the patient must be on file before any information can be given out. If for any legitimate reason the patient cannot sign the authorization, the hospital administrator should be consulted and he alone should assume responsibility for the release of information.

2. Photostatic copies of authorizations may be accepted.

3. Copies of completed hospital insurance forms are not to be given or sent directly to the patient.

4. A standard form of insurance report is to be drawn up and used in completing all reports except in the case of group insurance cases.

5. All requests for information contained in the medical record and all questions concerning medical care and diagnosis on insurance forms are to be completed in the medical record department.

A simplified insurance form, used routinely in filling out reports regardless of the type of form sent in by the insurance company, was adopted. The only exception was the original group insurance form, such as Blue Cross.

Completion of forms is made easier by including on the alphabetic index card the diagnosis at the time of discharge. For checking in case of inquiry, the date of completion is written in the left hand corner of the index card.

The form is completed without charge to the insurance company; where additional information is requested, a charge of $2 is made. Insurance representatives, with proper authorization, are allowed to make notes directly from the record in the presence of a department member. The representative is required to leave a carbon copy of the information taken from the chart and this copy is filed with the hospital record.

In order to avoid continual interruption, a schedule was found to be very satisfactory. Three days a week, the insurance forms are picked up from the accounting department where any financial data has been previously filled in. The necessary charts are pulled, the forms completed and then taken to the assistant administrator's office for signature.

—Doris Gleason, in "Hospitals", November, 1948, Hospital Abstract Service.

Erratum

On page 54 of our March issue we published the current listing of hospitals "approved" and those "commended" by the Canadian Medical Association for the training of interns. The name of the Halifax Infirmary, which should have been in the "commended" list, was omitted in error.